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Asst. OIC Unit Training Responsibilities Included: Teaching, coordinating and tracking classes in which personnel were trained to live in field conditions; supervising two personnel.

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ABSTRACT

The educational preparation of the occupational health nurse is fragmented at best. This poor educational foundation has a direct effect on the ability of occupational health nurses to carry out assigned responsibilities, as well as research in the field. In the past, the occupational health nurse's effectiveness was based on measuring improved client care. Present corporate economics have forced the occupational health nurse to ascertain the financial impact on the corporation of the occupational health nurse program. The purpose of this paper is to examine the educational preparation of the occupational health nurse and to ascertain how this preparation influences occupational health research. The responsibilities assigned to the occupational health nurse are reviewed, and measures to evaluate the nurse's effectiveness are described. An educational program for occupational health nurses commensurate with their responsibilities is proposed.

The Occupational Health Nurse and the Implications for Nursing Education

by

Denise M. Proctor

Seminar paper submitted to the Faculty of the Graduate School of the University of Maryland in Partial Fulfillment of the Requirements for the Degree of Master of Science

1992

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HISTORICAL PERSPECTIVE

The American Association of Occupational Health Nurses (AAOHN) defines occupational health nursing as "the application of nursing principles in conserving the health of workers in all occupations" (cited in Wilkinson, 1990, p. 73). McGrath's work documented well the early years of occupational health nursing (cited in Rogers, 1988). This type of nursing, formally called industrial nursing, emerged in England in 1878 during the advent of the industrial revolution. The role of the occupational health nurse (OHN) was much like that of the present day home health care nurse. The OHN provided direct nursing care at home for factory employees and their families who were sick and emergency care and treatment for employees at work. Phillipa Flowerday, working for the Colman Mustard Company, was the first documented British OHN. Later in the 19th Century, occupational health nursing came to the United States when the Vermont Marble Company hired Ada Mayo Stewart to care for their employees.

The first professional organization for OHNs was created in 1942 and was called the American Association of Industrial Nurses. In 1977 the name was changed to the American Association of Occupation Health Nurses to reflect the expanded roles of the OHN in health promotion, health education, safety and research (Rogers, 1988).

Despite the long history of occupational health nursing, this specialty of nursing is still immature (Atkins & Magnuson). It has failed to advance at the same rate as the technology of industry which created it and that of other nursing specialties. Businesses fail to fully utilize the OHN and OHNs themselves have been slow to advance their nursing specialty. Consequently, the people who could most benefit from occupational health nursing; miners, mill and factory workers, and nurses, have been underserved. Underserved in human terms meant that in Collins and Millar's 1990 study (cited in Daughton, 1990) of the 120 million American workers, 10 million were injured on the job and 10,000 lost their lives. Those workers who could most benefit from occupational health nurses were not named by Daughton (1990), but rather the profile from Collins' 1985 study (cited in Daughton, 1990) that young men between the ages of 17 and 44 were more apt to suffer from work related head injuries and, therefore, could benefit greatly from the expertise of an occupational health nurse was presented. As infrequent as work related head injuries occur, their severity in terms of lost work days and long term morbidity, makes the occupational health nurse invaluable in such cases. Daughton's (1990) focus was on work related head injuries and did not speak to new trends seen in the work place, such as repetitive motion injuries.

The purpose of this paper is to examine the educational preparation of the OHN and to ascertain how this preparation influences OH research. The responsibilities assigned to the OHN will be reviewed, as well as how the nurse's effectiveness is evaluated. An educational program for OHNs commensurate with their responsibilities will be proposed.

CHAPTER 1

EDUCATIONAL PREPARATION

Proper educational preparation is mandatory for the OHN to perform the job satisfactorily. Bertsche, health science specialist for the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA), Washington, D.C. stressed the importance of proper education preparation when delivering the Catherine Dempsey lecture at the 1990 American Occupational Health Conference. Bertsche stated that education is the key to a strong knowledge base focusing on well people in the work place; establishing credibility for the OHN; improving the image of nurses; advancing the profession; and reducing cost. It is critical for the OHN to be educationally prepared at the baccalaureate level for entry into practice than for hospital nurses because the OHN functions as an autonomous professional (Bertsche, 1990). According to Bodner, "more than 65 percent of occupational health nurses work without medical supervision" (Bodner, 1988). Unfortunately uniform educational programs to prepare OHNs are nonexistent worldwide. Reasons for this dearth of programs are lack of financial funds; suitability, flexibility, and proximity of courses; and qualified instructors. The World Health Organization (WHO) also recognizes that the multidisciplinary and interdisciplinary requirements of the

profession makes it difficult to develop a generic curriculum (cited in Radford & Wyatt, 1990).

The world situation is reflected in the United States. A survey conducted in 1991 of the 423 National League of Nursing accredited baccalaureate schools of nursing, in which 222 schools responded, showed that community health nursing faculty were responsible for teaching occupational health content, not qualified occupational health nursing faculty. The majority of the baccalaureate schools that responded offer only content related to nursing and the environment, and 50 percent only offer some content in occupational health nursing concepts and practice. Practicum experiences, vital for interactive learning, were reported by only 30 percent of the respondents (Rogers, 1991). Also, some courses that are needed to perform as an occupational health nurse may be offered at the undergraduate level, such as adult physical assessment, but do not provide a means for certification.

The AAOHN took steps in 1986 to help rectify deficiencies in the occupational health nurse's educational preparation by developing the "Code of Ethics" for the organization. According to the "Code of Ethics", "The occupational health nurse maintains individual competence in occupational health nursing practice, recognizing and accepting responsibility for individual judgements and actions, while complying with appropriate laws and

regulations (local, state, and federal) that impact the delivery of occupational health services" (AAOHN, 1986, p. 8/91) (see Appendix A). The AAOHN organization also issued a "Position Statement" supporting the baccalaureate degree in nursing (BSN) as the basic educational preparation for entry into practice (Kuhar, 1991) (see Appendix B). The "Standards of Practice" adopted by the AAOHN to ensure quality of care for employees and accountability of the OHN soon followed in 1988 (AAOHN, 1988) (see Appendix C).

The Code of Ethics, the Position Statement for entry into practice, and the Standard of Practice represent great progress for this specialty of nursing. However, the AAOHN met with resistance to these requirements by nurses within the ranks. This was shown to be the case by Kuhar's (1991) study which examined the educational preparation of 600 licensed occupational health nurses in the United States. The participants in the study were obtained through the use of the membership rolls of the AAOHN. The researchers chose the stratified random probability sampling technique based on educational levels allowing for generalization to the greater population. A two part mailed questionnaire developed by the researcher was the data collection tool.

The first part of the questionnaire asked for basic demographic information. The second part of the questionnaire asked for opinions regarding educational levels for initial registered nurse licensing, and for

practice in the specialty of occupational health nursing. The response rate for the questionnaire was 436 out of 600, which is equivalent to 72.7 percent. The overall results of the study showed that nurses support whatever school of nursing they attended, whether it be diploma, associate degree, or baccalaureate for both initial entry into nursing practice and for entry into occupational health nursing (Kuhar, 1991).

It seems that the specialty of occupational health nursing has become inured to the lack of educational preparation of those practicing in the field. The problem of the majority of OHNs prepared only at the diploma level, however, has not gone unnoticed by two schools. The University of Cincinnati and St. Joseph College are the forerunners in raising the educational levels of occupational health nurses. The University of Cincinnati offers a Bachelor of Science degree in Occupational Health Nursing for occupational health nurses wishing to further their education. St. Joseph College has an external Bachelor of Science degree in Health Care Management also designed for occupational health nurses wanting to progress educationally (cited in Radford & Wyatt, 1990).

The lack of educational preparation is not limited to the basic OHN. The multidisciplinary aspects of the OHN mentioned earlier makes the standardization of an educational program for the executive occupational health

nurse difficult. In 1990, Scalzi and Wilson conducted a study to develop an empirical basis for nursing administration curricula. The sample population that participated in the study were nurse executives from acute care, long-term care, home care, and occupational health care settings. Directory listings were used to obtain the random sample of 300 nurse executives. The average participant was 40-49 years old, female, with seven years of management experience. The data collection tool was a survey developed by two panels of experts in nursing administration. The survey addressed the current job functions of high level nurse executives. The response rate for the survey was 184 out of 300 surveys distributed, the equivalent of 61 percent. The results of the surveys were that curriculum containing courses in law and health care policy, organizational behavior, and organizational strategy are necessary for nursing administration regardless of practice setting. Nurse executives in the particular setting of occupational health need more courses in management information systems, in comparison to the other nurse executives that participated in the study, but fewer in finance and resource management (Scalzi & Wilson, 1990).

The above results are supported by another survey conducted by Scalzi, Wilson, and Ebert of the members of the American Association of Occupational Health Nurses' Corporate (Directors)/Executives Special Practice in 1991.

A panel of nursing experts in community based nursing and occupational health nursing developed the survey to look at OHN manager responsibilities in relation to their importance and amount of time allotted. A total of 72 surveys were distributed. Of those 72, 33 were returned, a response rate of 45.8 percent. The respondents were female with approximately 10 years of management experience. The results of this survey also found that "Management activities related to policy, practice standards, quality assurance, staff development, and systems for care delivery represented the core responsibilities of occupational health nursing management" (p. 116). "The curriculum recommendations given for management positions in occupational health included: health policy, program planning, and evaluation; business strategy; applications of management information systems; quality assurance; and marketing" (Scalzi, Wilson, & Ebert, 1991, p. 117).

Although professional development through traditional schools of nursing for the OHN is not widely available in the United States, the U.S. Public Health Service, Department of Health and Human Resources explains how the Occupational Safety and Health Act of 1970 mandated the National Institute of Occupational Safety and Health (NIOSH) to establish interdisciplinary Educational Resource Centers (ERCs). These centers provide training and education in occupational safety and health to nurses at the graduate

level (cited in Rogers, 1991). As of 1991, 14 ERCs were established at universities across the United States (Garcia & Nickolaus, 1991). Of these 14 established ERCs, 12 offer a master's degree and four offer a doctorate degree in occupational health nursing through the university's school of nursing or public health.

Master's prepared students complete one to two years of course work. The "core content usually includes: occupational health nursing theory and practicum; public health/health sciences; health program planning and development; interdisciplinary functioning; and special topics" (Rogers, 1990a, p. 540). A review of the core content indicates that a flaw in this program is that no other practicum is required other than the occupational health nurse theory practicum. Upon completion of the master's program, the occupational health nurse is qualified for positions in administration, occupational health specialties, or advanced clinical positions. The doctoral program prepares the OHN to teach at an institution of higher learning or to perform research. The statistics of the AAOHN show a meager 40 (0.34%) of its members as being prepared at the doctorate level (Rogers, 1990a). The American Board of Occupational Health Nurses has offered voluntary certification to OHNs since 1972 according to the AAOHN. Candidates are board certified as an OHN upon completion of an examination and the following:

1. Three years documented full-time experience in the field within the five years prior to the examination.

2. Seventy-five validated course contact hours offered by an accredited institution within the same five year window.

3. An additional two years of documented full-time experience in the field, for a total of five years of experience. Recertification is mandatory every five years and incurs an additional 75 hours of continuing education (cited in Radford & Wyatt, 1990).

Patricia Bertsche has made strides to improve the educational opportunities for the OHN. Bertsche developed an eight week OSHA Nurse Internship Program. In order to qualify for the program one must be an occupational health nurse graduate student. The nurse intern must complete a project during the course of the eight weeks that enhances the profession. This program allows for interactive learning and collaboration among other members in the profession. Bertsche has also arranged for continuing education credit to be earned by nurses for 23 of the courses offered at the OSHA Training Institute (Bertsche, 1990).

In 1991 a response from the OSHA course "OSHA - An overview for Occupational Health Nurses" identified that there is an ongoing need for the three day course as a means of keeping abreast of current topics. The AAOHN offers 21.6

contact hours of continuing education credit to OHNs that complete the course. OSHA has met this need by offering the course biannually in the future (Davis, 1991).

In summary, it is axiomatic that the educational routes for the OHN are disconcerting. The corporate world sees a RN as a RN regardless of whether one is associate, diploma, or baccalaureate prepared. As a result, the occupational health nursing field is saturated with diploma prepared nurses. The professional organization representing occupational health nurses, the AAOHN, has taken the position that the minimum education preparation is a BSN. However, Rogers (1991) study shows that even nurses prepared at the baccalaureate level are ill prepared to perform their jobs satisfactorily. Courses necessary to prepare the OHN to do an effective job, such as physical assessment, although offered at the undergraduate level, do not certify one to perform the task. There is still the additional credentialing offered by the American Board of Occupational Health Nurses, which is voluntary certification. A minimum standard of educational preparation to ensure adequate client care is necessary. The educational preparation for OHNs as it exists today can only be described as problematic at best.

CHAPTER 2

RESEARCH

Nursing literature and graduate level academia identify that the need for nursing research is great. Anne Belcher, RN, PhD, and Acting Chairperson for the Department of Psycho-physiological Nursing for the School of Nursing at the University of Maryland, Baltimore, addressed this need at the Professional Development in Nursing Program sponsored by the University of Maryland Medical System in February of 1992. Dr. Belcher conducted a workshop entitled "Getting Started in Research" in which the necessity for nursing research is to have a scientific base for practice, as a means to solve clinical problems, and ultimately improve the quality of patient care. Nursing can no longer depend on intuition or old and ingrained ways of doing things. Dr. Belcher pointed out that the difference between nursing research and medical research is that nursing research focuses on improving patient care and comfort, and thus often looks at quality of life issues. Medical research focuses on physiology and pathology and, thus, looks at longevity of life (Belcher, 1992).

Kirchoff (1987) proposes five patterns of interactions observed between nursing and medicine in relation to performing research. These five patterns are: blocking research, hidden research, dumping research, negotiated

research, and collaborative research. Collaborative research is identified above all others to have the greatest potential to affect improvements in patient care. Collaborative research for nursing is threefold. First, the nurse can participate in the research process as the primary investigator collecting data. Second, the nurse can act as an assistant by providing the eyes and ears for the primary investigator and reporting the information. Third, the nurse can enhance one's role as an interested and more astute health care professional by administering experimental drugs or providing nursing care for participants of a study.

Specifically when considering occupational health nursing research, Atkins and Magnuson looked at the prevalence of occupational health nursing research published in AAOHN Journal, Journal of Occupational Medicine, American Journal of Public Health, Image, Research in Nursing and Health, or Heart and Lung between June 1984 and June 1989. The results were that after reviewing 241 journals, 90 occupational health research reports were found to be nursing research. Hence, minimal nursing research was conducted. However, on a positive note, 50 percent of the studies were collaborative research with non-nurses. Criticism of the research that was conducted was that it lacked a theoretical framework and did not use nursing conceptual models (Atkins & Magnuson, 1990).

Because occupational health nurses devote much of their time toward changing clients behavior to improve their own health, Salazar (1991) looked at behavioral theories. Behavioral theories have been applied to research in this specialty in an attempt to predict or foretell what the impetus is for behavioral changes. Four behavioral theories that can be used are the Health Belief Model (HBM), Theory of Reasoned Action, Multiattribute Utility Model (MAU), and Theory of Self Efficacy. Rosenstock explains that "The HBM proposes that the likelihood that a person will take action concerning a health condition is determined by the person's readiness to take action and by the perceived benefits of action weighed against the perceived costs of barriers" (p. 129). Ajzen describes how the theory of Reasoned Action differs in that "The basic premise of the theory is that people are rational beings and, therefore, they consider their actions before they decide to perform or not perform a behavior" (p. 132). Regarding Beach's MAU model, "The assumption underlying this model is that a decision is a function of the ratio of perceived advantages of an alternative to its perceived disadvantages" (p. 133). Lastly, Bandura's Self Efficacy Theory maintains "The basic premise underlying this theory is that the expectation of personal mastery and success determines whether or not an individual will engage in a particular behavior" (cited in Salazar, 1991, p. 130).

Fitzgerald (1991) looks closely at Bandura's Self Efficacy Theory. It is composed of efficacy expectations and outcome expectations. Efficacy expectations are an individual's subjective perceptions as to whether or not they feel they can accomplish a task. Outcome expectations, are beliefs that a change in behavior will result in wanted outcomes. Past accomplishments or failures, role models, verbal encouragement or discouragement, and physiological symptoms are sources of efficacy information. When one studies this theory, the children's story "The Little Engine That Could" that repeated the phrase "I think I can, I think I can, I think I can ..." and eventually, managed to climb the mountain comes to mind. Self efficacy has been shown to be a factor in behavior modification in several studies. Fitzgerald (1991) cites the following examples of such studies: Condiotte's (1981) study on smoking cessation, Chambliss' (1979) study on weight management, Ewart's (1983) study on exercise and cardiac rehabilitation, Allen's (1990) study on functional status in clients one and six months after coronary artery bypass surgery, and Fitzgerald's (1989) study on individuals' ability to return to work who have undergone percutaneous transluminal coronary angioplasty (PTCA).

Fawcett (1989) believes that a nursing model should be visible throughout the research process (cited in Atkins & Magnuson, 1990). Nursing models that are being adapted for

use by occupational health nursing are Roy's Adaptation Model, Neumann's Systems Model, and Orem's Self Care Model (Atkins & Magnuson, 1990). Roy's Adaptation Model asserts that "The person continually scans the environment for stimuli so he can respond and adapt. Nursing has a unique goal to assist the person in his adaptation effort by managing the environment" (Blue, Brubaker, Fine, Kirsch, Papazian, & Riester, 1989, p. 330). In Neumann's Systems Model "The client is in a reciprocal relationship with the environment in that 'he interacts with this environment by adjusting himself to it or adjusting it to himself'". "The Neumann Model depicts the nurse as an active participant with the client and as 'concerned with all the variables affecting an individual's response to stressors'" (Harris, Hermiz, Meininger, & Steinkeler, 1989, p. 366). Orem's Self Care Model "shows that when an individual's self-care capabilities are less than the therapeutic self-care demand, the nurse compensates for the self-care or dependent-care deficits" (Eben, Gashti, Nation, Marriner-Tomey, & Nordmeyer, 1989, p. 123). However, Friend (1990) disagrees that nursing models are applicable to occupational health nursing. Friend advocates a new conceptual model specifically for occupational health nursing. This model is called the Hanasaari (named for a small town near Helsinki) conceptual model. The Hanasaari model was developed by Ruth Alston, an educational officer with the English National

Board. Alston used information from a Royal Graduate of Nursing Occupational Health Nurses' Forum annual conference held at that location to develop the occupational health nursing model. Friend describes the Hanasaari conceptual model as follows:

> The model builds on the traditional OH triangle of man, health and work. Around this triangle there is a circle of care, promotion, prevention, team work and research. Built around this is a pentagon of the broader, global concepts which are ecological, political, social, economic and organizational. OH nursing interaction lies at the center point. The sweeping arrows show the nurse reaching out to and embracing all the concepts. But in illustrating the model, the arrows can be turned inward. Here the implication inward is clear--either OH nurses expand and develop or they will go round in circles and possibly sink without a trace (Friend, 1990, p. 21) (see Appendix D).

Another model specific for occupational health nursing is Wilkinson's Windmill Model which focuses on converting healthy labor into production. The OHN is the central focus of this model. Communication between the OHN and the other members of the company are represented by the arrows around the OHN. The base of the windmill represents the qualities, skill, and educational preparation of the OHN. The windmill

blades represents the four main variables that affect the ability of the OHN to perform the job properly: the work environment; management; occupational health programs; and the interdisciplinary support team. There are five winds of influence that turn the blades of the windmill. They are social values, laws and regulations, politics, health care trends, and the economy. The OHN draws on one's knowledge base to work with the four main variables represented by the blades to keep abreast of the changing influences (see Appendix E). When the work of the OHN has been effective, the employees enjoy better health and produce more for the company (Wilkinson, 1990).

Another criticism of the existing occupational health nursing research made by Rogers (1990b) is that the majority of research that has been accomplished is conceptual. It addresses nursing roles, education, scope of practice, and program activities. In this day and age with an impending recession it is imperative that research has practical application for corporate management to support it. OHNs must perform research on clinical interventions and justify in dollars and cents how that particular intervention benefitted the company. One of the high priority areas according to Rogers is workplace hazards, to include biological, chemical, environment/mechanical, physical, and psychosocial. The NIOSH developed in 1988 a list of the 10 leading work-related diseases and injuries in an effort to

encourage research in these high priority areas (see Appendix F). Also, the National Centre for Nursing Research has been established at the National Institutes of Health to advance research in nursing and to train nurses how to perform research. Therefore, high priority research areas have been identified and the means to accomplish the research through the National Centre for Nursing Research is available. It is now a matter of doing what needs to be done. There is an enormous amount of work to be done by OHNs. In order to accomplish it, OHNs must focus primarily on the fiscal usefulness to the company, with improving the health status of those employed within the company as a secondary "perk" (Rogers, 1990b).

The lack of available nursing research provides a challenge for nurses wanting to work in occupational health nursing. Further research needs to be performed on the lifestyle of workers, on health promotion, on occupational safety factors, on nursing and emergency care in the work setting, and on rehabilitation of injured workers. Only through well conducted, reliable, and valid research; performed by OHNs and collaborative health teams; disseminated well to occupational health professions; can the nurse's role in occupational settings be strongly established to guide the professional practice (Atkins & Magnuson, 1990).

CHAPTER 3

RESPONSIBILITIES

The responsibilities assigned to the OHN vary depending upon an organization's size, philosophy regarding the welfare of the people that work within the organization, and available funding. Common tasks include implementing health promotion programs; identifying high risk factors associated with the work environment; administering nursing treatments and emergency care; implementing modified work programs; and keeping abreast of new influences in health care.

Health promotion is defined in the United States' Surgeon General's report as "that approach to health that begins with healthy individuals and seeks to enhance that state of health and help them to reach their highest level of functioning" (Rogers, 1990b, p. 143). When one studies the ten leading causes of death in the USA published by the United States Department of Health and Human Services National Center for Health Statistics, 1986, (see Appendix G) the important link between lifestyle and health is evident (cited in Rogers, 1990b). President Bush recognized this link and went on record supporting health prevention in a February 22, 1992, Washington Post article entitled "The Best Health Insurance". According to President Bush, "A large amount of the answer is prevention, and every one of

us can make changes in our behavior to reduce the risk of disease and illness" (McCarthy, 1992, p. A19).

The initial step for OHNs in health promotion is to perform a Health Risk Appraisal (HRA). A HRA is a lifestyle assessment tool. The employees complete a HRA, which is then compared to a mortality and epidemiologic database. The OHN can use the HRA in three ways. First, the OHN can utilize the information to develop client-specific educational programs and to assist the employee in changing behavior. Secondly, an initial assessment allows the OHN to identify high risk factors that may be insidious, but nonetheless adversely affect the client's health, such as high blood pressure. And thirdly, an initial assessment provides the nurse with baseline data on the employee from which to refer and note any changes in health over time. Data obtained from HRAs can be easily computerized, allowing the OHN to track large volumes of information. Being at the work site, the OHN is in an ideal position to continuously monitor the employees health status (Sherman, 1990).

Another responsibility of OHNs is that of identifying high risk factors associated with the particular work environment, intervening as necessary, monitoring the situation, and following up. "The National Safety Council (1985) reported an estimated 11,500 deaths, 80 million lost work days, and 33 billion dollars in direct and indirect costs due to work-related injuries" (cited in Hayes, 1990).

Injuries differ from accidents in that injuries can be prevented, whereas, accidents are freak, random events. Although, changes in lifestyle behavior have been stressed to improve employee health, when it comes to injury prevention 'passive' strategies implemented by corporate management are more effective.

Three 'passive' strategies are:

1. "Place a physical barrier between the hazard and the person" (Hayes, 1990, p. 126). The American Nurses Association position statement on HIV testing states that "In the United States it is estimated that there are between one and two million Americans infected with the virus that causes AIDS" (American Nurses Association, 1991) (see Appendix H). Therefore, an example of placing a physical barrier between the hazard and the person is surgical gloves worn by health care workers (American Nurses Association, 1991). Dr. Korniewicz is a nurse who started research on surgical gloves to determine how much they protect health care workers from body fluids. Dr. Korniewicz's research has provided evidence that latex surgical gloves provide a better protective barrier than vinyl gloves. Donning one pair of latex gloves provides a health care worker with the same protection as two pairs of vinyl gloves. However, there are disadvantages to the latex gloves. Latex gloves are more expensive than vinyl gloves. Also, because latex gloves are made from rubber trees, and no two rubber trees

are chemically alike, patients have experienced anaphylactic reactions to the latex gloves (Korniewicz, 1992).

2. "Modify the basic qualities of the hazard" (Hayes, 1990, p. 127). Examples of modifying the basic qualities of potential hazards are placing soft cushions on the corner of furniture to prevent injury and maintaining items at a height that is easily accessible.

3. "Increase an individual's resistance to injury" (Hayes, 1990, p.127). A physical fitness program designed especially for professionals that require physical endurance, such as police officers and firemen, is a good case in point.

One of the most vivid examples of a lack of injury prevention was the September 3, 1991 fire in a chicken processing plant in Hamlet, North Carolina. The plant had locked doors, unmarked exits, inadequate emergency lighting, no fire alarm system, and no sprinkler system. The plant had been in operation for 11 years, but had never been inspected. There are still 21 states which are solely responsible for enforcing OSHA standards, North Carolina being one of them. The other 29 states require federal intervention. The direct result of a lack of injury prevention in the chicken processing plant was that 25 people were killed and 56 people were injured (Patterson, 1991). This fire heightened congressional interest in a bill introduced by Representative William Ford of Michigan.

His "Comprehensive Occupational Safety and Health Reform Act" will impose stricter standards on employers to maintain safety and health programs in an effort to decrease work related hazards, injuries and illnesses to employees. The bill as of 17 March 1992 is still in hearings and has not reached the house floor (Ford, 1991) (see Appendix I & J).

Not only does a lack of injury prevention affect the employees of the company, but it can affect those residents who live within the vicinity of the company. For example, the television show "20/20" reported on March 13, 1992 how a sunglass manufacturing company in Leominister, Massachusetts, improperly disposed of hazardous wastes. The children who grew up there are now having a statistically higher number of autistic children as compared to the national average. These parents are now in the process of gathering and analyzing data to establish a link between the hazardous waste they were exposed to as children and the next generation of children being autistic (Crossley, 1992).

Regarding the OHN's responsibility to administer nursing treatments, a nurse can perform dressing changes. Also, under doctor's orders, a nurse can administer medications at the work site (Raper, 1990). An example of the OHN's responsibilities involving emergency care is writing, implementing, and operationalizing policies such as fire drills. The OHN must also be proficient in emergency medical procedures. The OHN must be able to stabilize the

injured employee, provide first-aid, activate the emergency medical system, ensure that the employee is transported to the proper institutions for definitive care, and follow up that rehabilitate care is available to the employee (Hayes, 1990).

The OHN can play a role in implementing modified work programs. Modified work programs involve allowing the employee to perform tasks they are able to do until the injury is stable and still receive their usual pay. Also, it can mean finding a new job within the organization for an employee who has a permanent disability. From a telephone interview study of three early return to work programs in which 33 employees from a steel foundry, a light precision cast parts manufacturing plant, and a metropolitan transportation district headquarters participated, a profile of workers at risk for poor outcomes was constructed. Also, recommendations to improve the design of the modified job were made, such as making the modified job more meaningful and more interesting. The modified job may be used as a learning experience and a career broadening experience. Lastly, the importance of employer concern and expression of that concern to the injured worker was highlighted. The work place can be an impersonal place, but when an employee is injured the personal touch by management may positively affect the workers attitude towards returning to work early (Williams, 1991).

Lastly, OHNs are responsible for keeping abreast of new influences in health care. Wilkinson put new influences in the realm of new social values, laws and regulations, politics, health care trends, and the economy (Wilkinson, 1990). OHNs must be aware of and knowledgeable of new diseases and conditions that may affect employees, such as acquired immune deficiency syndrome (AIDS) and carpal tunnel syndrome (Locklear-Haynes, 1990).

The term "ergonomics" has come into usage as "the adapting of the machine/work area to the employee to reduce worker stress." An excellent example of ergonomics is when the OHN trains an employee to work on a computer or a video display terminal with the emphasis on minimizing strain on the user's body (Jackson, 1991). According to the Summary of The Comprehensive Occupational Safety and Health Reform Act, "Between 1981 and 1989 reported cases of cumulative trauma disorders have increased five fold; about one in 500 American workers now suffer from this disorder, which is often irreversible" (Summary of the Comprehensive Occupational Safety and Health Reform Act, 1991, p. 5) (see Appendix J).

A change in demographics has affected the present day work force. Johnson's study shows that "By the year 2000, 49% of the work force will be between ages 35 and 54, and eight million persons will be older than age 80" (cited in Hart & Moore, 1992, p. 36). The nursing implication for the

change in demographics is that the OHN will have to refocus the health care delivery at the worksite to meet the special needs of the older worker. Also, the need for OHNs in nonindustrial settings is growing. Study results show that OHNs are needed in multi-specialty group medical practices and health maintenance organizations (HMOs) at a growing rate of 300% in the next 10 years (Teichman & Brandt-Rauf, 1990). Other non-traditional places in which OHNs are needed are in prisons (Bromstrup, 1988) and in international business such as the United Nations Medical Service (Molano, 1988).

While carrying out these numerous responsibilities, the OHN is in a precarious situation - working for management but in the best interest of the employee. The OHN may be afraid of losing one's position if it is necessary to go against management. Also, the OHN must be vigilant to protect client confidentiality. The American Association of Occupational Health Nurses and the American Nurses Association Code of Ethics can be used as a guide by the OHN regarding client confidentiality. If, however, the OHN is confronted with a situation involving illegal matters, such as illicit drug use, then it is best to consult a lawyer (Mistretta & Inlow, 1991).

CHAPTER 4

EVALUATION OF AN OHN'S EFFECTIVENESS

The benefits to the employee as a result of the hard work performed by the OHN are better health and morale. The benefits to the employer as a result of the hard work performed by the OHN are decreased employee absenteeism, higher employee productivity, decreased employer cost for sick benefits, decreased cost to the health insurance companies for disability claims, and financial savings associated with not having to retrain a temporary employee or replace the injured employee altogether. A study conducted in 1986 by Dellinger et al. described a savings to industry of $204,000 in one year through the use of occupational health practitioners (cited in Rogers, 1990b).

Traditionally, the OHN's effectiveness is evaluated through quality assurance programs. Quality assurance is defined by Migliozzi as "an objective, constructive evaluation based upon established standards" (cited in Randolph, 1988, p. 168). The focus of quality assurance programs is to measure or quantify the quality of care provided to the client. Methods used in quality assurance programs are peer review, audits, and self-evaluation (Randolph, 1988). A tool the OHN can use is an assessment guide to measure the quality of care provided (Manchester, Summers, Newell, Gaughran, & Spitler, 1991) (see Appendix

K). Presently, however, with the rising cost of health care, corporations require the OHN to justify one's effectiveness in terms of dollars and cents. The way in which to accomplish this task is to utilize a business approach. According to Ossler's (1987) study, "occupational health nurses must gain the skills and knowledge necessary to gather and interpret health care data, develop an action plan based on data analysis, present the plan for management approval, and evaluate the plan during the different stages of the implementation process" (cited in Dees & Taylor, 1990). The utilization records of the third party payers or administrators and the HRAs can be utilized by the OHN to gather health care data. Once the health care data has been gathered, it is analyzed, and trends are identified. Then, "case management" categorizes high cost clients into one of three categories. The three categories were first described in Henderson's (1987) study. "The first category includes clients who have experienced one episode of treatment for a major illness or injury requiring one long expensive hospitalization and intensive monitoring." "Category II includes persons with chronic conditions, such as cancer, heart disease, or AIDS." "Category III includes mental illness and substance abuse" (cited in Dees & Taylor, 1990, p. 56). Subsequently, the three stages of case management: identification of the cases; screening of the cases; and planning, coordinating, and referring of the cases is

accomplished. The decision as to whether the case will be handled internally, externally, or in combination of both internal and external resources is made. Studies of Henderson (1987) and Crowder (1989) support case management as a means of health care savings (cited in Dees & Taylor, 1990).

CHAPTER 5

COMPREHENSIVE EXAMINATION FOR MASTER'S PROGRAM

Comprehensive Examination for Master's Program: Critique of the body of literature and synthesis of the relationship of concepts:

The general strengths of the body of literature pertaining to occupational health nursing are that it recognizes the long history of occupational health nursing, identifies deficiencies in the field, and describes the many functions of the OHN. The historical foundation of this nursing specialty is well documented by McGrath (1945) (cited in Rogers, 1988). The literature legitimately identifies the two major deficiencies in the field, which are the lack of a standardized educational program to ensure quality client care and the lack of research in the clinical aspects of occupational health nursing. The nine functions of occupational health nursing are outlined by Brown (1981) (cited in Amann, Eichenberger, & Hogan, 1988) and described throughout the literature.

Unfortunately the literature is limited to only describing the current status of occupational health nursing. The benefits of utilizing the expertise of an occupational health nurse are assumed, supportive evidence is not necessarily provided. For the client the assumed benefits are: improved morale and health, convenience, and time saved from work. For the employer the assumed benefits

are: decreased employee absenteeism, higher employee productivity, decreased employer cost for sick benefits, decreased cost to the health insurance companies for disability claims, and financial savings associated with not having to retrain a temporary employee or replace the injured employee altogether. Literature that reports action plans, implemented interventions, and follow up evaluations by occupational health nurses is critically needed.

The ideas of major contributors to the field of occupational health nursing differ little in their critical assessment, evaluation, and vision for the future. They are in agreement as to the general educational status, research, and OHN's responsibilities to the point of redundancy. They do, however, disagree as to the methods to effect change.

Major deficits in research areas, as stated above, are in clinical occupational health nursing ares. According to Rogers (1990a), "Research on occupational health nursing roles, education, scope of practice, and programmatic activities are more abundant than clinical occupational health nursing research" (p. 541). Rogers (1990a) stresses the need for research on the outcomes and cost effectiveness of health promotion and preventative workplace hazard programs.

Four behavioral theories have been applied to occupational health nursing. They include: the Health Belief Model (HBM), Theory of Reasoned Action,

Multiattribute Utility Model (MAU), and Theory of Self Efficacy. They have been applied because of the need to change clients' behavior for the end result of improved health (cited in Salazar, 1991). However, Fawcett (1989) (cited in Atkin's and Magnuson, 1990) recommends applying nursing models to OHN research, such as Roy's Adaptation Model, Neumann's Systems Model, and Orem's Self Care Model, as a specialty within the nursing profession. Experts in the field of Occupational Health Nursing, like Friend (1990) and Wilkinson (1990), disagree that nursing models are applicable to this specialty and advocate new specific conceptual models, such as the Hanasaari and Windmill Model.

The major relevant concepts identified are the autonomous role of the OHN, the pro-active rather than reactive approach to improving client health care (self care), and passive strategies to encourage client compliance. The autonomous role is the basis of practice for nursing as a profession, to include nursing education. The progressive and rapidly growing acceptance of self care expands the need and opportunities for the nurse educator. The idea of implementing passive strategies to encourage client compliance is a novel idea for the nurse educator to seriously consider for operational use.

Recommendations:

1. A standardized educational program for Occupational Health Nursing.

2. Clinical research on health promotion and work place hazard prevention program outcomes and their cost effectiveness.

3. Increased research on biological, chemical, and physical workplace hazards.

4. Increased research on the design, implementation, and evaluation of nursing interventions.

5. A comprehensive, multi-dimensional preceptorship program which prepares the OHN for performing responsibilities.

6. Evaluation of the OHN's effectiveness according to client outcomes and industry cost benefit analysis.

PROPOSAL

Due to the many previously discussed adverse contributory factors, an educational program for OHNs commensurate with their responsibilities is idealistic. The first question that needs to be asked is, "Does one rearrange the basic nursing program to include courses on occupational health nursing? Does one enhance or add to a basic nursing program specialty courses of occupational health nursing? Does one develop a special program just for students who desire to be an OHN? Or, does one integrate occupational health nursing content into the existing nursing curriculum? Opinions on this subject differ considerably in the literature. "The WHO European Conference on Nursing in Vienna recommended that the education of nurses should be rearranged so that basic education would give possibilities for work in both hospitals and the community" (cited in Rossi & Heikkinen, 1990, p. 22). The International Labour Organization (ILO) recommends "a proposal for specialized training in occupational health nursing" (cited in Rossi & Heikkinen, 1990, p.21). According to Radford and Wyatt,

> The ideal programme for specialization for occupational health nurses, to ensure efficiency, relevance and cost-containment, would be one divided into three parts. The first part would be the core subjects

> needed by all professionals and all public health and community nurses. The second part would integrate those basic subjects from a number of disciplines which are needed by all occupational health and safety practitioners. The third part would be concerned with the art and science of occupational health nursing and the application by nurses of the knowledge and skills acquired in the first two (Radford & Wyatt, 1990, p. 174).

This author is in agreement that occupational health nursing content should be integrated into existing nursing curriculum, but takes the radical and very probably unpopular stance with the existing occupational health nursing community, that OHNs should complete a basic four year bachelor of science in nursing program (a total of 122 credits) and a two year nurse practitioner program (a total of 45 credits). Also, a one year preceptorship (a total of 8 credits) would be conducted concurrent with the last year of both programs. This judgment is made based on the nine functions of the occupational health nurse identified by Brown (1981) (cited in Amann, Eichenberger, & Hogan, 1988) (see Appendix L) which require the credentials of a nurse practitioner to perform them in entirety. For example, a nurse can participate in preplacement and periodic health assessments of workers, but a nurse practitioner can follow through with complete physical examinations, order

laboratory studies, and prescribe medications as needed. These on site services would save the company money that would otherwise be spent to contract out to a physician and would be much more convenient for the worker.

The preceptorship program is a critical component of this program. Amann, Eichenberger, and Hogan (1988) provide a model for precepting specific to the occupational health setting. Precepting is defined as "the art of guiding students through a clinical experience in the worksite and helping them gain an understanding of the care of the working adult" (p. 25).

At the undergraduate level an appropriate preceptorship site is a community health clinical and at the graduate level an appropriate preceptorship site is a worksite. A preceptorship program is a collaborative effort between the student, the university faculty member, and the preceptor. The preceptorship process involves three stages. These three stages are planning, preceptoring, and evaluating, and each stage has respective tasks (see Appendix M). Written agreements between the university and the worksite; written agreements between the university faculty member, the student, and the preceptor; and written objectives are necessary to provide a clear understanding of expectations and to prevent miscommunication. The expected outcomes of a preceptorship program are many, with the primary student

benefit of improved occupational health nursing skills (see Appendix N).

Easy accessibility to qualified schools is a major concern for individuals with an interest in a specialty field. In order to encourage individuals to become OHNs, an educational program should be readily available. At least one state school that has a BSN and nurse practitioner program should be dedicated to occupational health nursing. This state school should operate much like the Public Health Service. Students in the occupational health nursing track should receive a subsidy of fifty percent from the state and third party insurance companies. In return, the student upon graduation works as an OHN within the state for a prearranged number of years at a reduced salary. Once the student fulfills the time requirement, the salary is readjusted commensurate with their peers and years of experience. An incentive program could be developed to include such items as continuing education opportunities, health insurance, and retirement benefits to keep the occupational health nursing pool within that particular state.

As far as resource support is concerned, Seaver's (1985) study reports that a National institute of Occupational Health Nursing Education was established here in the U.S. by the American Association of Occupational Health Nurses in 1983 (cited in Radford & Wyatt, 1990).

State institutes could be mimicked after the National Institute. They could operate along side the state school as a resource for the students use and for OHNs throughout the state. The state institute could provide current written and multimedia materials, guest speakers, and newly released updates from the National Institute to the designated state school.

Also, innovations in occupational health nursing education must be introduced. The lack of trained OHNs throughout the United Kingdom prompted the Robert Gordon's Institute of Technology (RGIT) to develop a Diploma in Occupational Health Nursing course. Students in this course can attend classes up to three years and may attend in residence or through "distance learning". Distance learning is the United Kingdom's equivalent of self-instruction modules in the United States. In order to receive the diploma a total of seven credits must be earned; one for each of the six modules, and one for the work practicum and 10,000 word dissertation. The advantage of distance learning is that it is flexible and the OHN does not have to leave the work site (Lowis & Ellington, 1991). Perhaps distance learning could be utilized in the United States. A larger, more comprehensive program could allow the OHN a means to earn credits towards the existent master's or doctorate degrees, or the voluntary certification.

Occupational health nursing is a fascinating field of nursing with its many challenges for education and research and the numerous and ever changing responsibilities. The research has been done to indicate what educational preparation is needed by the OHN to perform the respective duties. It is time for monies to be allocated, curricula to be developed, and perspective OHNs to be trained.

CHAPTER 6

Adult Physical Assessment For Occupational Health Nurse Practitioners

Denise M. Proctor

University of Maryland School of Nursing

May 11, 1992

Table of Contents

Course Title: Adult Physical Assessment II--4 Credits

Course Overview

The course "Adult Physical Assessment II" is a comprehensive, in-depth physical assessment course designed to provide the knowledge and skills necessary for future occupational health nurse practitioners. This is the second of two sequential courses. The course reviews properly taking a health history; the four physical examination techniques; and the equipment required to perform the physical examination. The course also compares normal anatomy and physiology by body systems to alterations in anatomy and physiology by body systems. The course focus is on properly performing total body physical assessments on adults using the four physical examination techniques during the objective assessment phase of the nursing process. The teaching method includes two hours of lecture, one hour of nursing laboratory time for return demonstrations, and eight hours of clinical time per week either in an ambulatory setting or worksite. The learning outcome is that the student will be able to perform total body physical assessments on adults independently. The student will be able to identify any deviations from the norm, and using a problem-solving approach, assess the subjective and objective findings, make an accurate diagnosis, order appropriate interventions (i.e. laboratory diagnostic tests, radiology diagnostic tests), and develop a personalized plan

of care. As a course designed for future nurse practitioners with a specialty in occupational health, the course content will emphasize workplace hazards, such as biological, chemical, environmental/mechanical, physical and psychosocial, and how they affect the physical health of the worker. The student must be astute to the influences of the work environment that adversely affect the workers health based on the physical assessment findings and adjust the plan of care accordingly. Prerequisite: Anatomy and Physiology I and II, Pharmacology I and II, and Physical Assessment I.

Student Objectives

Upon completion of the course, the student will be able to:

1. **State the rationale behind performance of a complete physical assessment.**
2. **Describe and perform the four physical examination techniques.**
3. **Demonstrate a complete system assessment within 15 minutes in the nursing laboratory and record the demonstration on videotape for peer and instructor evaluation.**
4. **Under a preceptor's direct supervision, collect subjective and physical assessment data from patients at the clinical site, order appropriate diagnostic tests, analyze the data, determine the diagnosis, and develop a plan of care with 90% accuracy.**
5. **Document the above with 90% accuracy.**
6. **Given case studies with alterations in physical assessment, determine the culpable workplace hazard and develop a plan of care.**

Course Syllabus

Class Time	Content	Teaching Method
Mon. 0800 - 1000	I. Introduction A. Course Overview B. Review Student Objectives C. Review of health history taking, the four physical examination techniques; and the equipment required to perform the physical examination. II. The Physical Examination: An Introduction III. The Skin A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards IV. The Head, Face and Neck A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards V. The Eye A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards VI. The Ear A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards	Lecture, Audiovisual Techniques - Visual Aides - Video Tapes Case Studies Method

Course Syllabus

Class Time	Content	Teaching Method
	VII. The Nasopharynx	
	A. Normal Physical Assessment Findings	
	B. Alterations in Physical Assessment	
	C. Clinical Diagnosis and Management	
	D. Workplace Hazards	
	VIII. The Respiratory System	
	A. Normal Physical Assessment Findings	
	B. Alterations in Physical Assessment	
	C. Clinical Diagnosis and Management	
	D. Workplace Hazards	
	IX. The Cardiac and Peripheral Vascular System	
	A. Normal Physical Assessment Findings	
	B. Alterations in Physical Assessment	
	C. Clinical Diagnosis and Management	
	D. Workplace Hazards	
	X. The Breast	
	A. Normal Physical Assessment Findings	
	B. Alterations in Physical Assessment	
	C. Clinical Diagnosis and Management	
	D. Workplace Hazards	
	XI. The Abdomen	
	A. Normal Physical Assessment Findings	
	B. Alterations in Physical Assessment	
	C. Clinical Diagnosis and Management	
	D. Workplace Hazards	
	XII. The Female Genitalia	
	A. Normal Physical Assessment Findings	
	B. Alterations in Physical Assessment	
	C. Clinical Diagnosis and Management	
	D. Workplace Hazards	

Course Syllabus

Class Time	Content	Teaching Method
	XIII. The Male Genitalia A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards	
	XIV. The Musculoskeltal System A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards	
	XV. The Neurologic Examination A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards	
1000 - 1100	Nursing Laboratory A. Normal Physical Assessment Findings B. Alterations in Physical Assessment C. Clinical Diagnosis and Management D. Workplace Hazards	Audiovisual Techniques - Visual Aides - Videotapes Laboratory Teaching Hands on Practical Experience Return Demonstration Peer and Instructor Evaluation
8 Hrs./Wk.	Clinical	Teaching in the Clinical Setting One-on-One Teaching and Counselling Return Demonstration Preceptor and Instructor Evaluation

Evaluation of Student

Evaluation of the student consists of a written test and a videotaped return demonstration following the review of each body system. Two hours will be allotted for the written tests. The videotaped return demonstration is to be limited to 15 minutes and evaluated by the instructor and peers by a Physical Assessment Skills Competency Check List. A written evaluation of the student's performance during the clinical experience will be completed by the preceptor and returned to the course instructor mid-semester and at the end of the course. The student will complete an instructor, a preceptor, and a course evaluation at the end of the course. The course has been coordinated with the University of Maryland at Baltimore faculty. Credits assigned to this course is 4. A passing grade in this course is a B or above.

Letter Grade Equivalents

Letter Grade	Percentage Grade
A	90-100
B	80-89.4
C	70-79.4
D	60-69.4
F	Below 60
I	Incomplete

University of Maryland Medical Systems

Department of Nursing

Guidelines for Use: Basic Physical Assessment Skills Competency Checklist

1. Use the Skills Competency Checklist to assess basic physical assessment skills for current staff and Registered Nurse and Graduate Nurse orientees.

2. Rate the performance of each physical assessment competency skill using the following three-level rating scale:

   1 - Independently Performs (or correctly explains, if assessment not able to perform an assessment parameter)

   2 - Requires Assistance (Preceptor must ask frequent, prodding questions to elicit desired response)

   3 - Unable to perform

3. If the skills performer achieves a level two or three rating, an explanatory comment is required.

University of Maryland Medical Systems
Department of Nursing

Basic Physical Assessment
Skills Competency Checklist

Name: _____ Evaluator: _____

Unit: _____ Date: _____

The RN will demonstrate proficiency in the performance of a basic physical assessment, including the following assessment parameters.

Rating Scale: 1 - Independently Performs or Explains;
2 - Requires Assistance; 3 - Unable to Perform

Assessment Parameter:	**Rating:**	**Comments:**
I. Basic Techniques		
A. Inspection		
B. Auscultation		
C. Percussion		
D. Palpation		
II. Neurologic System		
A. Mental Status/ Orientation		
B. Movement/Strength (Presence of paresis or plegia)		
C. Gait		
D. Sensation		
E. Pupil Equality and Reaction		
III. Cardiovascular System		
A. Skin Temperature		
B. Skin Color		
C. Capillary Refill Test		

Assessment Parameter:	Rating:	Comments:
D. Pulse Palpation		
1. Apical		
2. Radial		
3. Femoral		
4. Popliteal		
5. Dorsalis Pedal		
6. Posterior Tibial		
7. Carotid (One side)		
E. Presence of Edema		
F. Presence of Pacemaker (Permanent or Temporary)		
G. Cardiac Auscultation (Rate/Regularity)		
H. Intake and Output		
IV. Respiratory System		
A. Airway type (Normal, tracheostomy, or ETT) and patency		
B. Breathing Pattern		
C. Respiratory Rate		
D. Cough (Describe)		
E. Secretions (Describe)		
F. Supplemental Oxygen (Type and Flow)		
G. Presence of Chest Tubes (Site, Air leak, Suction amount and Drainage)		
H. Chest Auscultation (Anterior and Posterior)		
1. Normal Airflow (Bronchial, Broncho-vesicular, Vesicular Sounds)		
2. Clear sounds		

Assessment Parameter:	Rating:	Comments:
3. Diminished/Distant		
4. Crackles		
5. Coarse		
6. Wheezes (I/E)		
V. Gastrointestinal System		
A. Abdominal Assessment		
1. Inspect for contour, movement, size, markings, etc		
2. Auscultate for bowel sounds		
3. Percuss for air and organ location		
4. Palpate to elicit tenderness, masses		
B. Presence of Tubes (Feeding, Surgical)		
C. Bowel Movements		
1. Date of Last B.M.		
2. Character of stool		
VI. Genitourinary System		
A. Void/Anuria		
B. Presence of Urinary Device (Foley, Supra-pubic, etc.)		
C. Continent/Incontinent		
D. Burning/Frequency		
E. Urine: Color/Character		
F. Palpate Bladder		
G. Intake and Output Review		
H. Vaginal/Penile Discharge		
I. Presence of Menses		

Assessment Parameter:	Rating:	Comments:
VII. Comfort/Rest		
A. Pain Assessment		
1. Accurate Location		
2. Pain Score (0 - 10)		
B. Patterns of Rest/Sleep		
VIII. Psychosocial		
A. Behavioral Responses		
B. Thought Processes		
IX. Skin Assessment		
A. Integrity		
B. Wound Staging		
C. Presence of rashes		
X. Wound Assessment		
A. Location		
B. Type (Surgical, Traumatic, Open, Sutured)		
C. Description/Drainage		
D. Presence of Drains and/or Devices		

UNIVERSITY OF MARYLAND

SCHOOL OF NURSING

NURS 000: OBJECTIVES FOR PRE- POST CONFERENCE

PRE-CONFERENCE

1. To provide direction for learning for the day.
2. To set the groundwork for analysis of the experience.
3. To recognize the scope and limitations of the nurse's role.
4. To reinforce "process" learning; for example, problem-solving, application of knowledge, and use of judgement.

POST-CONFERENCE

1. To analyze the clinical experience.
2. To clarify relationships between theory and practice.
3. To develop generalizations and guidelines in providing nursing care.
4. To clarify both thinking and feeling.
5. To keep the focus on patients as people.
6. To reinforce process learning.

Matheney, R. V. (1969). Pre and post-conferences. American Journal of Nursing, 69, 286-289.

Mitchell, C. A., & Krainovich. (1982). Conducting pre and post conferences. American Journal of Nursing, 82, 823-825.

UNIVERSITY OF MARYLAND
SCHOOL OF NURSING

NURS 000: EVALUATION OF STUDENT (Midsemester)

Clinical Teaching For Adult Physical Assessment II

DIRECTIONS:

In conjunction with Master Teacher, rate the following items according to the scale provided below:

5 = A 2 = D

4 = B 1 = F

3 = C N/A = Not applicable

Objective: To conduct clinical learning experiences, using a variety of approaches, based on the assessment of individual learning needs of students.

1. Assesses individual learning needs of students.	5	4	3	2	1	N/A
2. Selects a variety of learning experiences related to learner needs (in conjunction with master teacher).	5	4	3	2	1	N/A
3. Relates clinical laboratory experience to theory.	5	4	3	2	1	N/A
4. Modifies learning experiences based on evaluation of student response to learning (in conjunction with master teacher).	5	4	3	2	1	N/A
5. Establishes an atmosphere conducive to learning.	5	4	3	2	1	N/A
6. Conducts an effective pre-conference and post-conference for students.	5	4	3	2	1	N/A
7. Identifies barriers to student progress.	5	4	3	2	1	N/A

8.	Utilizes appropriate methods to evaluate student clinical performance (anecdotal records, skills performance, etc.)	5	4	3	2	1	N/A
9.	Communicates effectively with students both verbally and non-verbally.	5	4	3	2	1	N/A
10.	Assists students in relating	5	4	3	2	1	N/A
11.	Allows for increased independence in performance as student competency warrants.	5	4	3	2	1	N/A
12.	Participates in evaluation of students' clinical performance.	5	4	3	2	1	N/A

Master Teacher Comments:

Self-Assessment and Comments:

Overall rating in clinical teaching performance:

A = Excellent
B = Good
C = Fair
D = Poor
F = Unsatisfactory

UNIVERSITY OF MARYLAND
SCHOOL OF NURSING

NURS 000: EVALUATION OF STUDENT (Final)

Clinical Teaching For Adult Physical Assessment II

DIRECTIONS:

In conjunction with Master Teacher, rate the following items according to the scale provided below:

5 = A 2 = D

4 = B 1 = F

3 = C N/A = Not applicable

Objective: To conduct clinical learning experiences, using a variety of approaches, based on the assessment of individual learning needs of students.

1. Assesses individual learning needs of students.	5	4	3	2	1	N/A
2. Selects a variety of learning experiences related to learner needs (in conjunction with master teacher).	5	4	3	2	1	N/A
3. Relates clinical laboratory experience to theory.	5	4	3	2	1	N/A
4. Modifies learning experiences based on evaluation of student response to learning (in conjunction with master teacher).	5	4	3	2	1	N/A
5. Establishes an atmosphere conducive to learning.	5	4	3	2	1	N/A
6. Conducts an effective pre-conference and post-conference for students.	5	4	3	2	1	N/A
7. Identifies barriers to student progress.	5	4	3	2	1	N/A

8.	Utilizes appropriate methods to evaluate student clinical performance (anecdotal records, skills performance, etc.)	5	4	3	2	1	N/A
9.	Participates in evaluation of staff members performance.	5	4	3	2	1	N/A
10.	Uses appropriate teaching strategies to conduct clinical inservice programs (in conjunction with Master Teacher).	5	4	3	2	1	N/A
11.	Communicates effectively through verbal and non-verbal behavior.	5	4	3	2	1	N/A
12.	Participates effectively in departmental meetings, conferences and evaluations as needed.	5	4	3	2	1	N/A

Master Teacher Comments:

Self-Assessment and Comments:

Overall rating in clinical teaching performance:

A = Excellent
B = Good
C = Fair
D = Poor
F = Unsatisfactory

Instructor Evaluation

		Y	N	NA
1.	Did the instructor cover the stated objectives?			
2.	Was the instructor knowledgeable of the subject material?			
3.	Was the instructor enthusiastic about the subject material?			
4.	Was the instructor able to relay the information in a manner that was easily understood?			
5.	Did the instructor present the material in an orderly fashion?			
6.	Did the instructor encourage questions and answer them satisfactorily?			
7.	Did the instructor respect the allotted time limits for the class session?			
8.	Did the instructor use a variety of teaching methods and materials to maintain interest and facilitate learning?			

Any Additional Comments:

Document developed by Capt. Denise M. Proctor while attending the University of Maryland, School of Nursing.

UNIVERSITY OF MARYLAND
SCHOOL OF NURSING

NURS 000: EVALUATION OF MASTER TEACHER

DIRECTIONS:

In conjunction with Master Teacher, rate the following items according to the scale provided below:

5 = A 2 = D

4 = B 1 = F

3 = C N/A = Not applicable

Objective: To identify and evaluate various aspects of the teaching role.

1. Assists the student in developing realistic and appropriate objectives for the practicum.	5	4	3	2	1	N/A
2. Designs learning experiences which enhances student achievement of the objectives.	5	4	3	2	1	N/A
3. Provides guidance to the student in the clinical setting.	5	4	3	2	1	N/A
4. Encourages student to exercise independent judgements in the clinical situation.	5	4	3	2	1	N/A
5. Serves as a resource to the student during the practicum.	5	4	3	2	1	N/A
6. Allows the student to have input into clinical evaluations.	5	4	3	2	1	N/A
7. Provides adequate practicum supervision to the student.	5	4	3	2	1	N/A
8. Holds regular conferences with the student to provide feedback.	5	4	3	2	1	N/A

9. Guides the student to resources and references as needed throughout the practicum.	5	4	3	2	1	N/A

Student Comments:

Course Evaluation

The plan for the evaluation of this course is that the students evaluate both the course and the instructor.

Course Evaluation

		Y	N	NA
1.	Did the course spark and retain your interest?			
2.	Was the course applicable to your work setting?			
3.	Did the course meet your professional and personal needs?			
4.	Did the methods of instruction facilitate your learning?			
5.	Were the handouts, references, reading materials, and equipment available and readily accessible?			
6.	Did the examinations reflect content covered in the course?			
7.	Did the hands-on return demonstration allow you to put into practice the principles learned in the lecture?			
8.	Was the classroom environment conducive to learning (the lighting, ventilation, temperature, and noise level were adequate)?			
9.	Did the course increase your knowledge of concepts and principles related to adult physical assessment?			
10.	Do you plan to keep abreast of the new trends in adult physical assessment?			

Any Additional Comments:

Document developed by Capt. Denise M. Proctor while attending the University of Maryland, School of Nursing.

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Nursing Laboratory Videotapes

Call Number	ID #	Title
1	VT	Diabetes
4	VT	Rehabilitation for Stroke Patient
7		Nursing Care of the Cancer Patient With Compromised Immunity: Concepts and Care
8		Nursing Care of the Cancer Patient With Compromised Immunity: The Nursing Process
9		Nursing Care of the Elderly Patients With Acute Cardiac Disorders
10		Nursing Care of the Elderly Patient With Chronic Obstructive Pulmonary Disease
33	VT 2	Kathleen McCullough Lecture
48	VT	Behavioral Treatment of Urinary Incontinence
50	VT	Chronic Renal Failure and Dialysis
52	VT	Cystic Fibrosis and Nursing. The Courage...
70	VT	The Dynamic Kidney
72	VT	BCS: Surgical Wound Care
75	VT	Physical Exam - Head, Face, Mouth and Neck
76	VT	Physical Exam - Eyes, Ears, and Nose
77	VT	Physical Exam - Thorax and Lungs
78	VT	Physical Exam - Cardiovascular: Peripheral
79	VT	Physical Exam - Cardiovascular: Neck Vessels
80	VT	Physical Exam - Breasts and Axillae
81	VT	Physical Exam - Abdomen
82	VT	Physical Exam - Male Genitalia, Anus, Hernia
83	VT	Physical Exam - Female Genitalia, Anus, Hernia
84	VT	Physical Exam - Musculoskeletal System
85	VT	Physical Exam - Neurologic: Cranial Nerves and Sensory System
86	VT	Physical Exam - Neurologic: Motor System and Reflex
87	VT	Assessing Breath Sounds

Nursing Laboratory Videotapes

88	VT	Basics: Urinary Care
95	VT 2	Adult Physical Assessment
103	VT	Skin Cancer: Preventable and Curable
104	VT	Prostate Cancer: What Everyone Should Know
111	VT	Breast Self Examination: Just 5 Minutes
112	VT	Detecting Early Melanoma
115	VT	Cancer Detection and Prevention
135	VT	Endocrine System
146	VT 4	Alteration in Hydration
		Neuro Exam
		Nursing the Cancer Patient
		Medicine, 1965 Stroke
		Nursing Care of Patient With Diabetes
		Physical Exam - Male Genitalia, Anus and Rectum
		Physical Exam - Peripheral Vascular Septum
		Physical Exam - Female Genitalia, Anus & Rectum

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APPENDIX A

APPENDIX A

CODE OF ETHICS AND INTERPRETIVE STATEMENTS

Preamble

The AAOHN Code of Ethics has been developed in response to the nursing profession's acceptance of its goals and values, and the trust conferred upon it by society to guide the conduct and practices of the profession. As a professional, the occupational health nurse accepts the responsibility and inherent obligation to uphold these values.

The Code of Ethics is based on the belief that the goal of the occupational health nurse is to promote worker health and safety. This specialized practice is devoted to health promotion, prevention, and management of illness and injury at the worksite. The client can be both an individual worker or an aggregate worker population. The purpose of the AAOHN Code of Ethics is to serve as a guide for the registered professional nurse to maintain and pursue professionally recognized ethical behavior in providing occupational health services.

Ethics is synonymous with moral reasoning. Ethics is not law, but a guide for moral action. Universal moral principles are utilized by the professional nurse when making judgements related to the health and welfare of the worker or worker population.

The most significant principle for the occupational health nurse is autonomy, or the right to self-determination, which encompasses respect for an individual's right to privacy and refusal of treatment. Confidentiality and truth-telling are related concepts. Other key principles are beneficence (doing or producing good); nonmaleficence (avoiding harm); and justice (fair and nondiscriminatory treatment of all individuals).

Occupational health nurses recognize that dilemmas may develop that do not have guidelines, data, or statutes to assist with problem resolution; thus, the occupational health nurse may use problem-solving, collaboration, and appropriate resources to resolve dilemmas.

In summary, the Code of Ethics and Interpretive Statements provide a guiding ethical framework for decision-making and evaluation of nursing actions as occupational health nurses fulfill their professional responsibilities to society and the profession. The Code is not intended to establish nor replace standards of care or minimal levels of practice.

1. The occupational health nurse provides health care in the work environment with regard for human dignity and client rights, unrestricted by considerations of social or economic status, national origin, race, religion, age, sex, or the nature of the health status.

The profession of occupational health nursing is dedicated to the promotion, protection, and preservation of the life and health of every client. Occupational health nurses render nonprejudicial and nondiscriminatory care to clients in every situation and setting, regardless of the nature of the health problem.

Occupational health nurses have an obligation to treat clients fairly, respecting their dignity and worth. While recognizing tne existence of a vast diversity of cultural beliefs and values in society, occupational health nurses demonstrate respect for these beliefs and values inherent in their clients and themselves, and plan health care services for and with that client accordingly.

The occupational health nurse respects the client's right to autonomy. Clients are encouraged to participate in planning their own health care and occupational health nurses are truthful in providing clients with necessary information to make an informed judgement. As client advocates, occupational health nurses have the responsibility to be knowledgeable about the client's rights. These rights include acceptance or refusal of care and are acknowledged by the professional nurse. When personal convictions of the occupational health nurse prohibit participation in providing health services and/or when the client refuses care, the nurse may not be exempt from client health care protection. While respecting the client's interest and well-being, the nurse examines the short-term and long-term outcomes of the decision-making process. The occupational health nurse avoids abandonment and refers clients to available, alternative sources of care.

2. The occupational health nurse promotes collaboration with other health professionals and community health agencies in order to meet the health needs of the workforce.

The occupational health nurse is a member of the occupational health and safety team. The occupational health nurse functions both interdependently and independently in promoting the welfare of clients. Providing health services to clients requires a commitment to collaborative planning with other health professionals and members of the occupational health team. The occupational health nurse makes referrals to appropriate community resources and seeks assistance and expertise from other *recognized* health professionals in the provision of services, as appropriate. The occupational health nurse functions within the scope of nursing practice and delegates responsibility to members of the health and safety team as necessary.

Occupational health nurses have an obligation to promote adequate distribution of health care and nursing resources to meet clients' needs. The occupational health nurse is responsible to management as an employee. As a professional, the occupational health nurse is an advocate for the workers. *The occupational health nurse recognizes situations in which the interests of management and workers may conflict.*

As a professional, the occupational health nurse has a responsibility to observe professional codes and uphold practice standards. The occupational health nurse demonstrates fairness in conflict resolution. The promotion of health and safety and prevention of injury and illness at the worksite req. ires occupational health nursing representation and participation in the decision-making process within the institutional and political arenas. Occupational health nurses are encouraged to become and remain participants in decision-making processes that define or pertain to occupational health nursing functions or activities.

3. *The occupational health nurse strives to safeguard the employee's right to privacy by protecting confidential information and releasing information only upon written consent of the employee or as required or permitted by law.*

Occupational health nurses have an obligation to maintain the trust bestowed upon them by ıe client and to protect the client's right to privacy. Public trust is ensured by maintaining the ɔnfidentiality of health information through prevention of unauthorized access. Written policies ıd procedures should be developed regulating the access, release, transmittal, and storage of :alth information, including computerized records.

Occupational health nurses are encouraged to use current professional literature and resources r guidance. The occupational health nurse is knowledgeable about and adheres to the organiza- ɔnal, local, state, and federal policies and laws governing access to confidential information. nployees are then protected from unauthorized and indiscriminate access and disclosure of :alth and/or personal information. Confidentiality is crucial to the effectiveness of the occupa- ɔnal health program.

4. *The occupational health nurse strives to provide quality care and to safeguard clients from unethical and illegal actions.*

Occupational health nurses are dedicated to providing quality, competent, and professional rvices to their clients. Each occupational health nurse is a representative of the profession and :monstrates competent, ethical, and professional conduct and accountability. The profession's imary commitment is to the health, safety, and welfare of clients. The occupational health nurse rives to protect the client and the profession from incompetent professionals and individuals ho misrepresent themselves and the profession. Any person or persons who exhibit incompe- nce or engage in unethical or illegal activities may be reported to licensing, accrediting, or rtifying authorities, as may be appropriate. The occupational health nurse should participate in e development of policies to promote competent, ethical, and legal nursing practice. Occupa- ɔnal health nurses have a commitment to comply with the laws and regulations that govern the ɔrkplace in an effort to provide workers with a safe and healthful workplace.

5. *The occupational health nurse, licensed to provide health care services, accepts obligations to society as a professional and responsible member of the community.*

As a licensed health professional, the occupational health nurse has an obligation to the client, ployer, community, society, and profession to demonstrate credibility and competence. The upational health nurse is a responsible citizen in the community adhering to all laws and utes (local, state, and federal), including those governing occupational health practice. As a fessional, the occupational health nurse respects the client's and society's right to know and eceive factual information about potential and actual job and environmental hazards. The upational health nurse is knowledgeable of community issues and dilemmas affecting health, ty, and the welfare of society, and participates in appropriate resolution when able.

6. *The occupational health nurse maintains individual competence in occupational health nursing practice, recognizing and accepting responsibility for individual judgements and actions, while complying with appropriate laws and regulations (local, state, and federal) that impact the delivery of occupational health services.*

The profession of occupational health nursing is dedicated to promoting competent professional practice. Occupational health nurses have the responsibility to strive for excellence and maintain a level of knowledge, judgement, technical skills, and professional values necessary for delivering health services. Individual professional licensure provides for protection of the public to ensure that basic professional competencies have been achieved. The occupational health nurse utilizes professional and educational activities to improve professional practice.

Occupational health nurses may engage in professional, educational, and quality assurance activities, such as peer review. The occupational health nurse acknowledges the importance of continued and advanced educational activities beyond the basic level of nursing education. As professionals, occupational health nurses have a personal and professional responsibility to maintain competence in practice. All occupational nurses are professionally and morally accountable for their actions and compliance with nurse practice acts, standards of practice, and other laws/regulations governing occupational health practice. In a situation where the occupational health nurse does not have the necessary skills or knowledge or is unable to render services personally, the nurse has a moral responsibility to refer the client to appropriate services.

7. *The occupational health nurse participates, as appropriate, in activities such as research that contribute to the ongoing development of the profession's body of knowledge while protecting the rights of subjects.*

Research is an integral part of occupational health nursing practice. Research provides new information to improve and validate the tenets underlying the profession's scope of practice. This validation can be accomplished by designing studies, testing theories to guide nursing practice, utilizing and applying research findings, or participating in the research processes. Occupational health nursing, as an applied discipline, engages in scholarly inquiry to build upon the body of knowledge that serves as the foundation for practice. Occupational health nurses must strive to create and expand this body of knowledge, both empirically and theoretically, through research activities.

Research activities are usually approved by appropriate bodies, such as institutional review boards. Occupational health nurse researchers should respect and protect the autonomy, rights, and privacy of the subjects. One mechanism to ensure this respect and protect subjects is by voluntary informed consent. The occupational health nurse has a moral obligation to self, the client, the profession, and society to conduct sound ethical research. Occupational health nurses have the responsibility to communicate and disseminate research findings to other occupational health nurses and professionals and to appropriately utilize research findings within their practice.

AAOHN

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APPENDIX B

APPENDIX B

AAOHN's POSITION STATEMENT ON BASIC EDUCATIONAL PREPARATION

AAOHN supports the baccalaureate degree in nursing as basic preparation for entry into professional practice. Implementation of this position will result in nurses prepared with additional theoretical and clinical skills to meet the responsibilities of occupational health care... We endorse the implementation of appropriate mechanisms to protect the professional status of those registered nurses currently practicing in occupational health (AAOHN, 1986).

APPENDIX C

Standards of Practice

INTRODUCTION

Recognizing the legal, social, ethical, and technological factors that affect health care delivery, a professional association has a responsibility to develop standards of practice based upon the scope of nursing practice. These standards provide for the protection of both the public and the profession.

Establishing standards enables a profession to insure the quality of the provider's service to the consumer by gaining control of its practice. Standards of professional practice require ongoing revision because the scope of nursing practice changes, and the knowledge base becomes more refined.

The format of this presentation of occupational health nursing standards is standard, rationale (interpretation), and criteria for determining achievement. The component related specifically to nursing practice is consistent with the nursing process, which is a systematic approach to nursing practice: assessment, planning, implementation, and evaluation.

SCOPE OF OCCUPATIONAL HEALTH NURSING PRACTICE

Occupational health nursing applies nursing principles in promoting the health of workers and maintaining a safe and healthful environment in occupational settings.

The knowledge is a synthesis of principles from several disciplines in the health sciences including, but not limited to, nursing, medicine, safety, industrial hygiene, toxicology, administration, and public health epidemiology.

Occupational health nursing activities focus on health promotion, protection, maintenance, and restoration of health. The occupational health nurse is primarily concerned with the preventive approach to health care, which includes early disease detection, health teaching, and counseling.

The occupational health nurse is the key to the delivery of comprehensive occupational health services. Responsibilities are influenced by current policies and trends in health care delivery and legislation as well as social and economic factors. The activities involved may be divided into five major categories: Direct Care, Education/Counseling, Management/Administration, Ethical/Legal, and Health and Environmental Relationships.

Direct Care involves nursing assessment, planning, implementation and evaluation in the prevention of illness and injury, and treatment and rehabilitation of those with occupational and non-occupational illness and injury. In Education/Counseling activities, the nurse utilizes principles of health education and counseling in individual and group intervention strategies.

The Management/Administrative component requires knowledge and application of management theory in organizing, staffing, equipping, maintaining, and evaluating employee health services. The Ethical/Legal category involves knowledge of and compliance with state nurse practice acts, standards of care, code of ethics, position descriptions/policies and procedures, and federal, state, and local health and safety legislation. Health and Environmental Relationships involves health status assessment and environmental evaluation, interpretation of findings and follow-up along with disease prevention, control, and research.

Whether the nurse is a sole provider or supervises other nurses and paraprofessionals, standards of care are applicable to nursing practice in all types of occupational health settings. Standards focus on nursing practice rather than on the health care provider.

As a professional, the occupational health nurse is accountable for the nursing care provided to the employee first and to the employer second. Standards of nursing practice provide a means for determining quality of care, as well as accountability of the practitioner.

STANDARD I

Policy

A defined philosophy, goals, and

The Standards of Practice were adopted by the AAOHN Board of Directors in January 1988.

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specific objectives are established for the health and safety program. They provide direction for:

- The health services that are implemented in relation to real and potential health hazards in the work environment.
- The health status of employees.
- The health needs of employees.

Rationale

This standard describes the interrelationships, lines of communication, lines of authority and responsibility among the nursing staff and other professionals such as managers, physicians, industrial hygienists, and safety engineers. Specific objectives provide for evaluating the nursing component as it relates to the occupational health program.

Process Criteria

Philosophy, goals, and objectives for the health and safety program are consistent with those of management. They are developed in collaboration with other health or safety members of the health care team. They are maintained in a policy manual. They are reviewed and revised periodically to be current with services provided in the work environment.

Outcome Criteria

A policy manual for components for the occupational health program includes:

- Philosophy.
- Organizational chart/company description.
- Goals and specific measurable objectives.
- Scope of health services (organization, staffing, and programs).
- Interrelationships with community (referral resources, consultants).
- Position descriptions.
- Personnel policies.
- Protocols appropriate to setting to cover emergency situations, episodic health problems, chronic health problems, and rehabilitation.
- Administrative procedures (health service record, reports, confidentiality, and accountability).
- Ethical/legal aspects of practice.
- Health and environmental relationships.

STANDARD II

Personnel

The occupational health nursing service is administered by a qualified professional nurse. Sufficient staff (professional, allied health, and paraprofessional), with adequate time and authority to design and implement the nursing service as set forth in policy, are necessary to insure a quality service.

Rationale

The nursing component of the occupational health and safety service is under the direction and supervision of a registered professional nurse with work experience and educational qualifications to assume the position. The preferred basic level of education is the baccalaureate nursing degree from an approved program and certification as an occupational health nurse.

Since the majority of occupational health nurses practice in single nurse units, these providers must possess skills in decision making, problem solving, independent nursing judgment, and communication. In addition, they need a broad knowledge base in general nursing.

Process Criteria

Adequate orientation to the products and processes in the occupational environment, including an understanding of health and safety hazards, is mandatory for all staff. Adequate and appropriate steps should be taken to hire qualified staff. Staff participate in periodic interdisciplinary meetings to coordinate program activities and promote communication.

Periodic performance reviews, based on position descriptions, are conducted for all staff.

Provision is made for staff development opportunities such as continuing education activities to facilitate skill refinement/development. Membership in professional organizations is encouraged. Consultants

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are used as necessary for specific programs, problems, or at orientation.

Outcome Criteria

There are:

- Written professional and paraprofessional staff requirements including functions, credentials, skills.
- Clearly delineated staffing patterns.
- Written position descriptions for each level of staff.
- Written policies regarding staff meetings, staff, and professional development opportunities, access to and utilization of consultants, mechanisms for personnel evaluations.
- Budgets for the nursing component as well as the overall occupational health program.

STANDARD III

Resources

Management provides adequate resources (equipment and facilities) to facilitate the implementation of an occupational health program.

Rationale

The size and configuration of the health care unit is determined by the number of employees, their health needs, hazards of the specific industry, and the extent of the clinical practice.

Process Criteria

Nursing staff participate in the design of facilities and selection of equipment. Initial and ongoing assessment of equipment and facility needs are conducted.

Planning occurs for both the nursing component and the overall occupational health program. Equipment and facilities are evaluated periodically for appropriate and efficient utilization.

Outcome Criteria

The following space is provided:

- Waiting area.
- Office(s) for nursing staff.
- Examination room(s).
- Treatment room(s).
- Rest area(s).
- Private area or health education conference area (counseling and interviewing, individual or group).
- Library space (current references, journals, literature for the professional nurse and consumer).
- Storage area.

Appropriate materials, resources, and equipment should be available to meet the program requirements. For example:

- Basic life support.
- Audiometric testing.
- Pulmonary function testing.
- Vision testing and tonometry.
- Stress testing.
- Health education.

Sufficient equipment of good quality and current with developing technology is provided. Equipment is well maintained and properly used. Records of equipment maintenance and calibration are kept in compliance with regulation requirements.

STANDARD IV

Nursing Practice

The occupational health nurse utilizes the nursing process to provide health care directed toward health promotion, health maintenance, disease prevention and rehabilitation for workers, and to provide a safe and healthy work place. The nurse is accountable for all aspects of the nursing care provided.

Rationale

Nursing process provides an organizing framework to ensure that effective comprehensive care is delivered. Increased health of workers and a safer environment result in decreased illness, injury, and absenteeism.

Process Criteria

The nurse:

- Applies the nursing process to systematically and continually collect data concerning the health status of the worker and real and potential health hazards in the workplace.
- Derives nursing diagnoses from this assessment.
- Develops a plan of care or plan of action which includes goals, objectives, and nursing activities.
- Evaluates nursing intervention on an on-going basis to set future goals, reorder priorities, and revise care plans.
- Involves the worker in all phases of the nursing process.
- Collaborates with other members of the occupational health team in designing and implementing an appropriate and effective health care plan.
- Participates in development and implementation of research in collaboration with the interdisciplinary team.
- Reviews and revises all policies, procedures, and protocols that relate to occupational health nursing practice.
- Develops and maintains a record and reporting system that meets legal requirements and insures continuity of care and confidentiality.
- Maintains legal requirements for practice.
- Participates in professional activities.

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tcome criteria

data base is established and ludes:
Comprehensive health history, ncluding an occupational history.
Physical assessment.
Screening and baseline laboratory ests.
dentification of high risk employ-es.
dentification of environmental ıigh risk areas.

Programs for determining health tus are developed and include:
Screening.
Physical examinations (job placement, periodic, health surveillance).
Epidemiological studies.

Safety and health hazard assessnts are conducted on a regular is (by the nurse when qualified, h referral to interdisciplinary team en appropriate) and include:
dentification of safety and health ıazards.
Identification of new processes ınd products.
Adequacy of personal protection equipment program.
Adequacy of personal hygiene pro-ram.

Written care plans identify:
Nursing problems.
Nursing diagnoses.
Nursing activities for problem sol-ing.
Method of evaluation.

Health promotion programs are ıblished and include:
Screening.
Risk reduction.
Counseling for individuals and roups of employees.
Health education for individuals nd groups of employees.

Staff conferences are conducted for:
- Periodic review of health care needs of employees.
- Periodic interdisciplinary planning.
- Evaluation of nursing services including:
  - counseling and health education activities.
  - rehabilitation activities.
  - treatment activities.
  - written nursing procedures and protocols for practice.

Accurate, complete, concise records of nursing activities are maintained.

The nursing practice adapts to the changing factors that influence nursing, and incorporates:
- Current research findings.
- State of the art practices and procedures.
- Ethical beliefs.
- Legal obligations.
- Governmental recommendations, standards, and regulations.
- Technological, social, political, and historical factors.
- Expanding knowledge base.
- Changes in employee demographics and environmental conditions.

The impact of the nursing practice results *long-term* in a measurable:
- Decreased incidence of occupational illnesses and injuries.
- Increased healthy lifestyle behaviors of employees.

STANDARD V

Evaluation

A systematic evaluation of the occupational health nursing program is conducted on a periodic basis to determine goal achievement.

Rationale

Both outcome and process evaluation methods are used to measure the effectiveness and efficiency of the nursing practice.

The evaluation process incorporates data from various sources. Evaluation findings are used to improve the quality of nursing care. Accountability includes formal quality assurance programs as well as reporting.

Process Criteria

Evaluation data are incorporated into the assessment phase of the nursing process. Reliable and valid data collection techniques are utilized.

The evaluation findings are used to revise, add, or delete services to improve the quality of nursing care and achieve the goals of a safe and healthful work environment.

OUTCOME CRITERIA

An evaluation program is present and is conducted periodically. An outcome evaluation is conducted at the end of a program or at the end of the fiscal year. Sources for evaluation data include:
- Walk-through assessment.
- Interdisciplinary team (management, medicine, industrial hygiene, etc.) input.
- Worker survey.
- Statistical information.
- Nursing care plans.
- Health records.
- Incidence records.
- Performance evaluations.
- Absenteeism, insurance, committee, and other pertinent records.

Reports are generated to provide justification for the occupational health nursing program and to share with management and other key individuals in the company.

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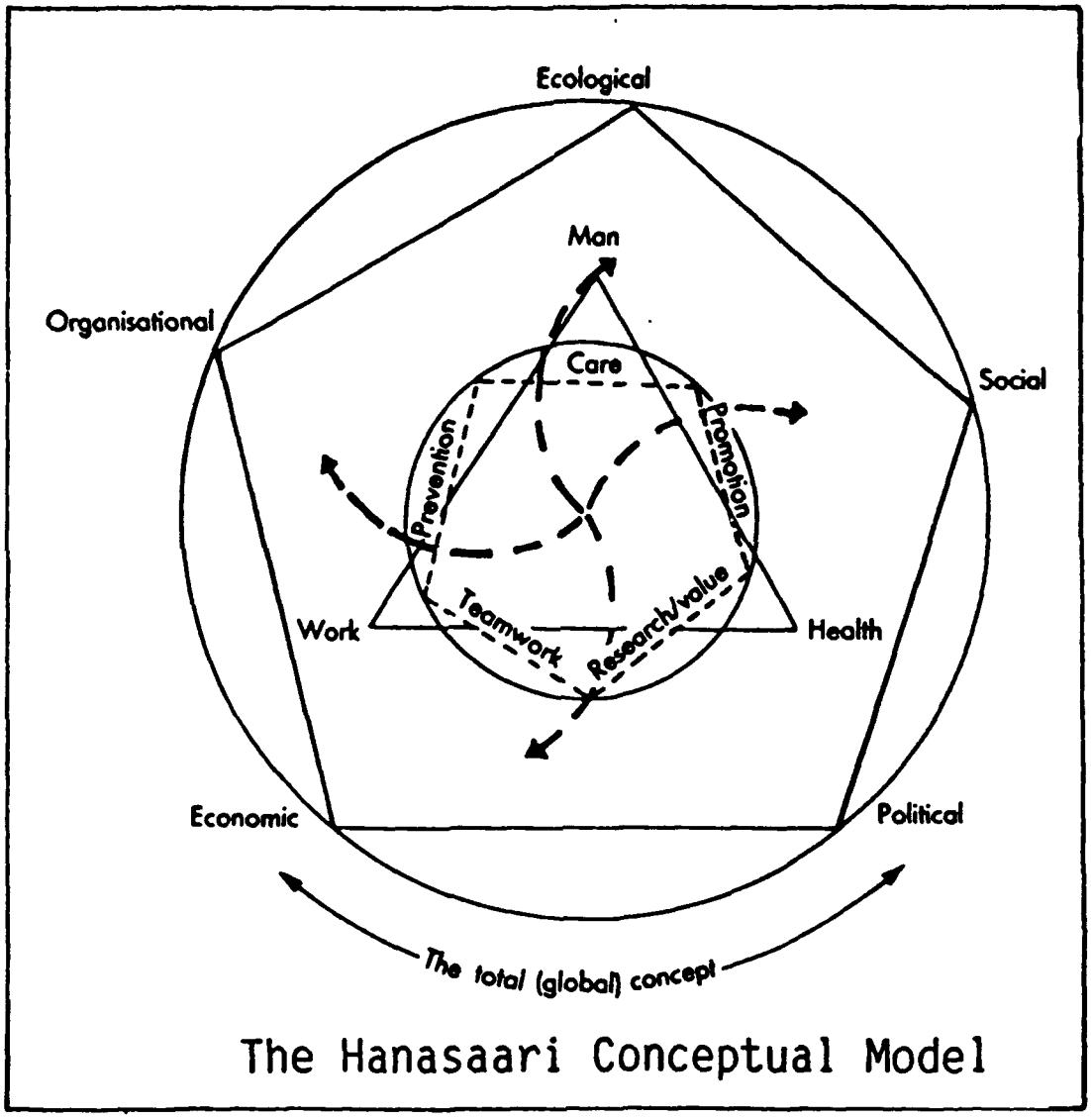
APPENDIX D

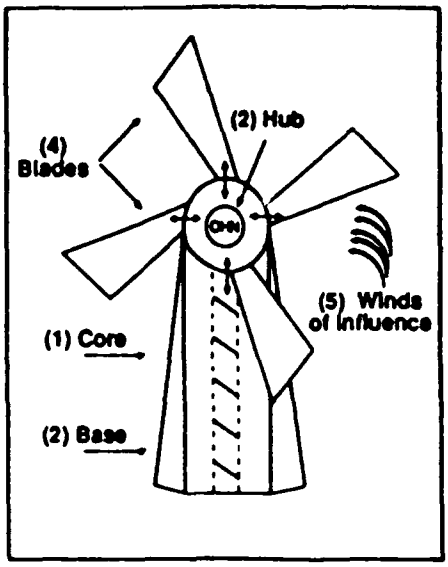
APPENDIX D

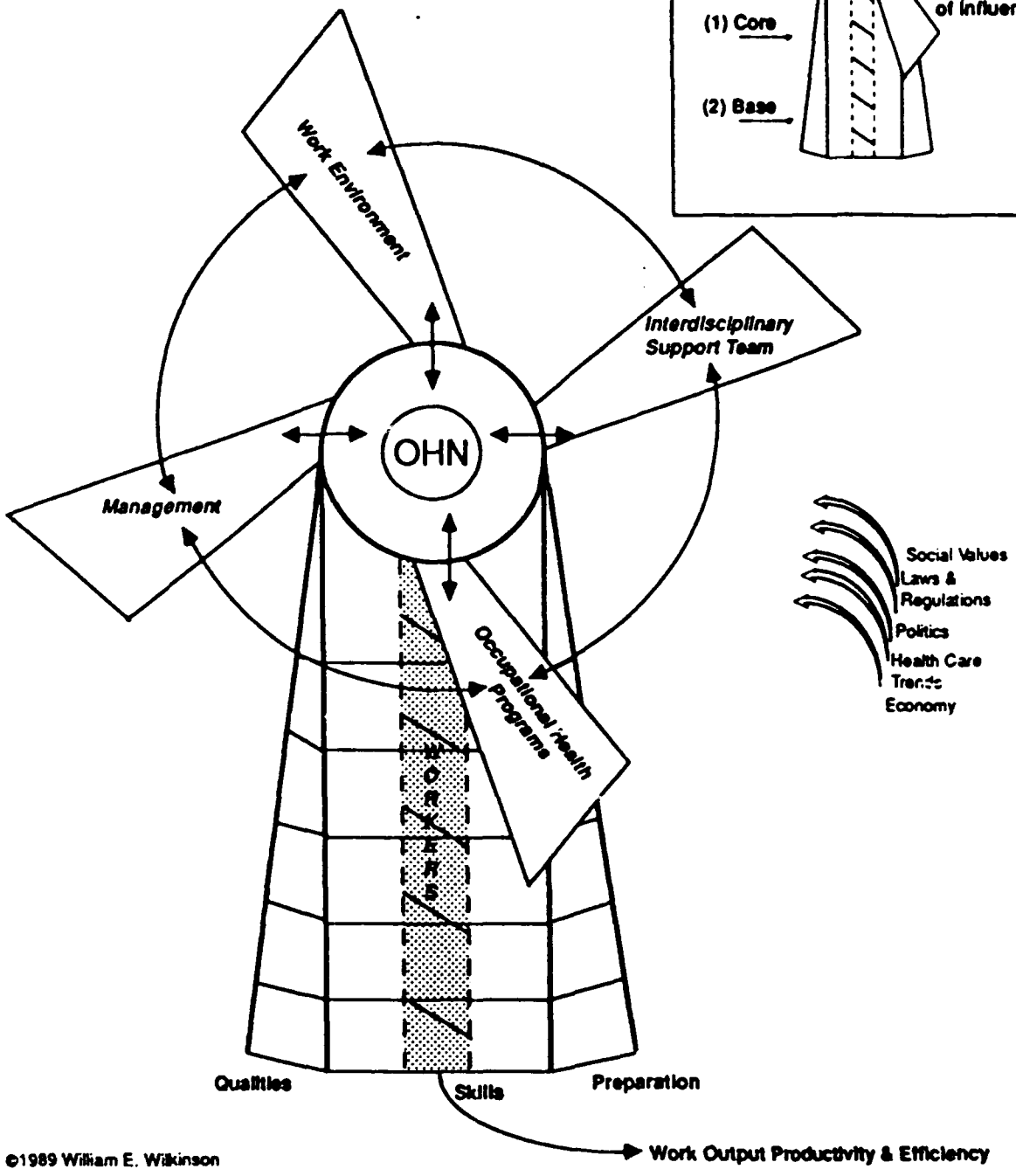


The Hanasaari Conceptual Model

APPENDIX E

Wilkinson Windmill Model of Occupational Health Nursing





APPENDIX F

APPENDIX F

The 10 leading work-related diseases and injuries, USA, 1982

1. Occupational lung disease: asbestosis, byssinosis, silicosis, coal workers' pneumoconiosis, lung cancer, occupational asthma.

2. Musculoskeletal injuries; disorders of the back, trunk, upper extremity, neck, lower extremity; traumatically induced Raynaud's phenomenon

3. Occupational cancers (other than lung): leukaemia; mesothelioma; cancer of the bladder, nose, and liver

4. Amputations, fractures, eye loss, lacerations, and traumatic deaths

5. Cardiovascular disease: hypertension, coronary artery disease, acute myocardial infarction

6. Disorders of reproduction infertility, spontaneous abortion, teratogenesis

7. Neurotoxic disorders: peripheral neuropathy, toxic encephalitis, psychoses, extreme personality changes (exposer-related)

8. Noise-induced loss of hearing

9. Dermatologic conditions: dermatoses, burns, contusions (abrasions)

10. Psychologic disorders: neuroses, personality disorders, alcoholism, drug dependency

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The conditions listed under each category are to be viewed as selected examples, not comprehensive definitions of the category.

Source: NIOSH, "Leading Work-Related Disease and Injuries - United States," Morbidity and Mortality Weekly Report, 21 January 1983.

APPENDIX G

APPENDIX G

Ten Leading Causes of Death in the USA, 1982

Cause of death	Percentage of all deaths
1. Heart disease	38.3
2. Cancer	22.0
3. Stroke	8.0
4. Accidents/adverse effects	4.8
5. Chronic obstructive pulmonary disease	3.0
6. Influenza and pneumonia	3.5
7. Diabetes mellitus	1.8
8. Suicide	1.4
9. Chronic liver disease and cirrhosis	1.4
10. Atherosclerosis	1.4
All others = 15.4%	

Source: United States Department of Health and Human Services National Center for Health Statistics, 1986

APPENDIX H

AMERICAN NURSES ASSOCIATION

Position Statement on HIV Testing

Summary: The American Nurses Association (ANA) opposes perpetuation of the myth that mandatory testing and mandatory disclosure of HIV status of patients and/or nurses is a method to prevent the transmission of HIV disease, and therefore does not advocate mandatory testing or mandatory disclosure of HIV status. ANA supports the availability of voluntary anonymous or confidential HIV testing which is conducted with informed consent and pre- and post-test counseling. ANA continues to support education regarding the transmission of HIV/AIDS and the use and monitoring of universal precautions to prevent HIV/AIDS transmission.

HIV disease and its consequences continue to be the number one public health problem in the world today. In the United States it is estimated that there are between one and two million Americans infected with the virus that causes AIDS. Most of those infected are asymptomatic and, even more disturbing, unaware that they are infected. While there have been many medical advances in the treatment of HIV related illnesses, there still is no cure or vaccine to prevent AIDS and the spread of HIV. Current knowledge about the progression of disease in HIV-infected persons indicates that early intervention with appropriate counseling and health care can interrupt the spread of the virus to others and delay the onset of infections and/or conditions associated with the diagnosis of HIV related disease and AIDS.

The availability of social, medical, health and community resources to those who seek testing is as vital as having testing available. HIV testing needs to be readily available and easily accessible to anyone wishing to be tested. Every effort should be made to expand and extend existing programs, thus allowing those who may be at risk the opportunity of receiving counseling and testing.

HIV testing—

- should be readily available.
- must always be conducted with informed consent and in conjunction with pre- and post-test counseling.
- can serve to prevent the progression of HIV/AIDS by enabling early medical intervention which can help the individual sustain a healthy, productive life.
- should not be considered a prevention means unto itself.
- should be done anytime an occupational exposure occurs in order to establish a baseline for referral and for the purpose of follow up testing, counseling, and intervention.
- should be considered as primary prevention for the purpose of partner notification with sexual or needle sharing contacts.
- can be utilized for epidemiological data collection to further enhance the scientific study of HIV disease.

HIV Testing Program

COUNSELING: In the establishment of any HIV testing program the most important component is counseling. The purpose of counseling is 1) to help uninfected individuals initiate and sustain behavioral changes that will reduce their risk of HIV infection, 2) to assist infected individuals to avoid infecting others, 3) to assist at-risk individuals during follow-up, and 4) to facilitate access to early interventions. Advance in research means that counseling and testing can also help to identify infected persons for whom early intervention would enable health maintenance to be sustained. All counseling should be done face to face and conducted in a private space by a skilled, trained person. Adequate time should be allotted for any questions. The pre-test counseling needs to include an explanation of the difference between anonymous and confidential testing.[1] At the conclusion of the pre-test counseling, the patient should be fully informed to the modes of transmission, risk behaviors, and strategies for prevention. The patient needs to sign an informed consent, indicating they understand the meaning of the test

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[1] The issues of disclosure and the protections that should be afforded to the infected person (patient or worker) can be described on a continuum of disclosure from none (blind test results) to full disclosure.

BLIND • ANONYMOUS • CONFIDENTIAL • LIMITED DISCLOSURE • FULL DISCLOSURE

Anonymity includes: 1) no identifiers, 2) no disclosure, 3) specific consent given for HIV testing, 4) counseling pre- and post-testing, and 5) availability in a variety of settings.

Confidentiality includes: 1) identifiers, 2) informed specific consent (signed or not) given prior to any testing, 3) pre- and post-test counseling, 4) protected records/information, 5) pertinent information is known to a limited few, 6) information on partner notification or tracing may be part of the process and 7) availability in a variety of settings.

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APPENDIX I

) CONGRESS
1ST SESSION

H. R. 3160

To revise the Occupational Safety and Health Act of 1970.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 1, 1991

?ORD of Michigan (for himself, Mr. GAYDOS, Mr. CLAY, Mr. MILLER of ?alifornia, Mr. MURPHY, Mr. KILDEE, Mr. MARTINEZ, Mr. OWENS of New York, Mr. HAYES of Illinois, Mr. PERKINS, Mr. SAWYER, Mr. ?AYNE of New Jersey, Mrs. UNSOELD, Mr. WASHINGTON, Mr. SERRANO, Mrs. MINK, Mr. JEFFERSON, Mr. OLVER, and Mr. DE LUGO) introduced he following bill; which was referred jointly to the Committees on Education and Labor and Post Office and Civil Service

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A BILL

revise the Occupational Safety and Health Act of 1970.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

ECTION 1. SHORT TITLE; REFERENCE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the Comprehensive Occupational Safety and Health Reform ct".

(b) REFERENCE.—Except as otherwise specifically ovided, whenever in this Act an amendment or repeal

is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Occupational Safety and Health Act of 1970 (29 U.S.C. 651 et seq.).

(c) TABLE OF CONTENTS.—The table of contents is as follows:

SEC. 2. FINDINGS.

Congress finds that—

(1) during the past two decades progress has been made in reducing workplace deaths, injuries,

and exposure to toxic substances through efforts of Federal agencies, States, employers, employees, and employee representatives;

(2) despite the progress described in paragraph (1), work-related injuries, illnesses, and deaths continue to occur at rates that are unacceptable and that impose a substantial burden upon employers, employees, and the Nation in terms of lost production, wage loss, medical expenses, compensation payments, and disability;

(3) employers and employees are not sufficiently involved in working together in joint efforts to identify and correct occupational safety and health hazards;

(4) employers and employees require better training to identify safety and health problems;

(5) Federal agency standard setting has not kept pace with knowledge about safety and health hazards;

(6) enforcement of occupational safety and health standards has not been adequate to bring about timely abatement of hazardous conditions or to deter violations of occupational safety and health standards.

(7) millions of employees exposed to serious occupational safety and health hazards are excluded from full coverage under the Occupational Safety and Health Act of 1970; and

(8) the lack of accurate data and information on work-related deaths, injuries, and illnesses has impeded efforts to prevent such deaths, injuries, and illnesses.

'ITLE I—SAFETY AND HEALTH PROGRAMS

101. SAFETY AND HEALTH PROGRAMS.

(a) IN GENERAL.—Section 27 (29 U.S.C. 676) is ıded to read as follows:

'. 27. SAFETY AND HEALTH PROGRAMS.

"(a) IN GENERAL.—

"(1) PURPOSE.—Each employer shall establish and carry out in accordance with this section a safety and health program to reduce or eliminate hazards and to prevent injuries and illnesses to employees.

"(2) MODIFICATIONS TO SAFETY AND HEALTH PROGRAMS.—The Secretary may by regulations issued under subsection (c)(1) modify the application of the requirements of this section to classes of employers where the Secretary determines that, in light

of the nature of the risks faced by the employer's employees, such a modification would not reduce the employees' safety and health protection.

"(3) WORKSITE DEFINITION.—As used in this section and section 28, the term 'worksite' means a single physical location where business is conducted or operations are performed by employees of an employer.

"(b) REQUIREMENTS.—Each employer covered by this section shall establish and carry out a written safety and health program that includes—

"(1) methods and procedures for identifying, evaluating, and documenting safety and health hazards;

"(2) methods and procedures for correcting the safety and health hazards identified under paragraph (1);

"(3) methods and procedures for investigating work-related illnesses, injuries, and deaths;

"(4) methods and procedures for providing occupational safety and health services, including emergency response and first aid procedures;

"(5) methods and procedures for employee participation in the implementation of the employer's safety and health program, including participation

through a safety and health committee established under section 28, where applicable;

"(6) methods and procedures for responding to the recommendations of a safety and health committee;

"(7) methods and procedures for providing safety and health training and education to employees and to members of a safety and health committee established under section 28;

"(8) the designation of a representative of the employer who has the qualifications and responsibility to identify safety and health hazards and the authority to initiate corrective action where appropriate;

"(9) in the case of a worksite where employees of two or more employers work, procedures for each employer to protect employees at the worksite from hazards under the employer's control, including procedures to provide information on safety and health hazards to other employers and employees at the worksite, and;

"(10) such other provisions as the Secretary requires to effectuate the purposes of this Act.

"(c) REGULATIONS ON EMPLOYER SAFETY AND HEALTH PROGRAMS.—

"(1) IN GENERAL.—The Secretary shall within one year of the effective date of the Comprehensive Occupational Safety and Health Reform Act issue final regulations on employer safety and health programs required by subsection (a).

"(2) REGULATIONS ON TRAINING AND EDUCATION.—The regulations of the Secretary under paragraph (1) respecting an employer's safety and health program shall—

"(A) provide for training and education of employees, including safety and health committee members, in a manner that is readily understood by such employees, concerning safety and health hazards, control measures, the employer's safety and health program, employee rights and applicable laws and regulations;

"(B) provide for training and education of safety and health committee members concerning methods and procedures for hazard recognition and control, the conduct of worksite safety and health inspections, the rights of the safety and health committee, and other information necessary to carry out the activities of the committee under section 28;

"(C) require that training and education be provided to employees at the time of employment and to safety and health committee members at the time of selection; and

"(D) require that refresher training be provided on at least an annual basis and that additional training be provided to employees and to safety and health committee members when there are changes in conditions or operations that may expose employees to new or different safety or health hazards or when there are changes in safety and health regulations or standards under this Act that apply to the employer.

"(3) NO LOSS OF PAY.—Training and education provided in accordance with the regulations of the Secretary shall be considered hours worked and shall be provided by an employer at no cost, and with no loss of pay, benefits, or seniority to employees of the employer.".

TITLE II—SAFETY AND HEALTH COMMITTEES AND EMPLOYEE SAFETY AND HEALTH REPRESENTATIVES

SEC. 201. SAFETY AND HEALTH COMMITTEES AND EMPLOYEE SAFETY AND HEALTH REPRESENTATIVES.

Section 28 is amended to read as follows:

"SEC. 28. SAFETY AND HEALTH COMMITTEES AND EMPLOYEE SAFETY AND HEALTH REPRESENTATIVES.

"(a) REQUIREMENT.—Each employer of 11 or more employees shall provide for safety and health committees and employee safety and health representatives in accordance with this section.

"(b) SAFETY AND HEALTH COMMITTEE.—

"(1) IN GENERAL.—Each employer covered by this section shall establish a safety and health committee at each worksite of the employer (hereinafter in this section referred to as the 'committee'), except that by regulation the Secretary may modify the application of this requirement—

"(A) to an employer whose employees do not primarily report to or work at a fixed location;

"(B) to covered employers at worksites at which less than 11 employees are employed; or

"(C) to worksites where employees of more than one employer are employed.

Each employer required to establish a committee shall, pursuant to regulations issued by the Secretary, enable the committee to exercise the rights set forth in this section.

"(2) MEMBERSHIP.—Each committee shall consist of the employee safety and health representatives elected or appointed under subsection (c)(2) and, as determined by the employer, up to an equal number of employer representatives.

"(3) CHAIRPERSONS.—Each committee shall be cochaired by—

"(A) an employer representative, selected by the employer; and

"(B) an employee representative, selected by the employee members of the committee.

"(4) RIGHTS.—Each committee shall have the right, within reasonable limits and in a reasonable manner, to—

"(A) review any safety and health program established under section 27;

"(B) review incidents resulting in work-related deaths, injuries, and illnesses and complaints regarding safety or health hazards by employees or committee members;

"(C) review, upon request of the committee or upon request of employer or employee representatives on the committee, the employer's work injury and illness records, other than personally identifiable medical information, and other reports or documents relating to occupational safety and health;

"(D) conduct inspections of the worksite at least once every 3 months and in response to complaints regarding safety or health hazards by employees or committee members;

"(E) conduct interviews with employees in conjunction with inspections of the worksite;

"(F) conduct meetings at least once every 3 months and maintain written minutes of such meetings;

"(G) observe the measurement of employee exposure to toxic materials and harmful physical agents;

"(H) establish procedures for exercising the rights of the committee;

"(I) make—

"(i) recommendations on behalf of the committee and in making such recommendations permit any member of such committee to submit the separate views of such member, or

"(ii) recommendations on behalf of the employer or employee representatives on such committee,

to the employer for improvements in the employer's safety and health program and for the correction of hazards to employee safety or health, except that such recommendation shall be advisory only and the employer shall retain full authority to manage the worksite; and

"(J) accompany the Secretary or the Secretary's representative during any physical inspection of the worksite under section 8(a).

"(5) TIME FOR COMMITTEE ACTIVITIES.—The employer shall permit members of the committee to take such time from work as is reasonably necessary to exercise the rights of the committee, without suffering any loss of pay or benefits for time spent on duties of the committee.

"(6) REGULATIONS.—The Secretary shall, within one year of the effective date of the Comprehensive Occupational Safety and Health Reform Act, issue final regulations for the establishment and functioning of committees. The regulations shall include provisions on the following:

"(A) the establishment and functioning of committees by an employer whose employees do not primarily report to or work at a fixed location;

"(B) the establishment and functioning of committees by a covered employer at worksites at which less than 11 employees are employed;

"(C) the establishment and functioning of committees at worksites where employees of more than one employer are employed; and

"(D) the employer's obligations to enable the committee to function properly and effectively, including the provision of facilities and materials necessary for the committee to conduct its activities and the maintenance of records and minutes developed by the committee.

"(c) EMPLOYEE SAFETY AND HEALTH REPRESENTATIVES.—

"(1) IN GENERAL.—The committees shall include—

"(A)(i) one employee safety and health representative at each worksite where the average number of nonmanagerial employees of the employer during the year ending January 1 was more than 10, but less than 50;

"(ii) two representatives where the number of employees is more than 50 but less than 100; and

"(iii) an additional employee safety and health representative for each additional such 100 employees, up to a maximum of 6 employee safety and health representatives, except as provided in paragraph (2)(C); or

"(B) where an employer's employees do not primarily report to or work at a fixed location, at worksites that have less than 11 employees of a covered employer, or at worksites where employees of more than one employer are employed, the number of employee safety and health representatives as determined by the Secretary by regulation.

"(2) SELECTION.—Employee safety and health representatives shall be selected by and from among the employer's nonmanagerial employees, as follows:

"(A) Where none of the employer's employees at a worksite are represented by an exclusive bargaining representative, the employees shall elect employee safety and health representatives in an election held in conformity with procedures established by regulations issued by the Secretary.

"(B) Where the employer's employees are represented by a single exclusive bargaining representative, the bargaining representative shall designate the employee safety and health representatives.

"(C) Where the employer's employees are represented by more than one exclusive bargaining representative or where some but not all of the employees are represented by an exclusive bargaining representative, each collective bargaining unit of represented employees and any group of unrepresented employees shall have a proportionate number of employee safety and health representatives based on the number of employees in each collective bargaining unit or

group, except that each unit of 11 or more employees shall select at least one representative.

"(3) REGULATIONS.—The Secretary shall, within one year of the effective date of the Comprehensive Occupational Safety and Health Reform Act, issue regulations on safety and health representatives. Such regulations shall include provisions on—

"(A) the number of employee safety and health representatives where an employer's employees do not primarily report to or work at a fixed location;

"(B) the number of employee safety and health representatives with regard to worksites with less than 11 employees of a covered employer;

"(C) the number of employee safety and health representatives at worksites where employees of more than one employer are employed; and

"(D) procedures for the selection and election of employee safety and health representatives which provide for a free and fair election by secret ballot and protect employees' equal rights to participate in the election without

being subject to penalties, discipline, improper interference, or reprisal of any kind.

"(d) ADDITIONAL RIGHTS.—The rights and remedies provided to employees and employee safety and health representatives by this section are in addition to, and not in lieu of, any other rights and remedies provided by contract, by other provisions of this Act or by other applicable law, and are not intended to alter or affect such rights and remedies.".

TITLE III—COVERAGE

SEC. 301. EXTENSION OF COVERAGE TO PUBLIC EMPLOYEES.

(a) DEFINITION OF EMPLOYER.—Section 3(5) (29 U.S.C. 652(5)) is amended by striking out "but does not include the United States or" and inserting in lieu thereof "including the executive and judicial branch of the Government and the Botanic Garden, the General Accounting Office, the Government Printing Office, the Library of Congress, the Office of Technology Assessment, the Congressional Budget Office, and the Copyright Royalty Tribunal of the legislative branch of the Government and".

(b) CONFORMING AMENDMENTS.—

(1) Section 19 (29 U.S.C. 668) is repealed.

(2) Section 410(b) of title 39, United States Code, is amended by amending paragraph (7) to read as follows:

"(7) the Occupational Safety and Health Act of 1970 (29 U.S.C. 651 et seq.);".

SEC. 302. APPLICATION OF ACT.

Section 4(b) (29 U.S.C. 653(b)(1)) is amended by redesignating paragraphs (2), (3), and (4) as paragraphs (5), (6), and (7), respectively, and by striking out paragraph (1) and inserting in lieu thereof the following:

"(b)(1) Where a Federal agency has promulgated and is enforcing standards or regulations affecting occupational safety or health of some or all of the employees within that agency's regulatory jurisdiction, and the Secretary determines that such a standard or regulation as promulgated and the manner in which the standard or regulation is being enforced provides protection to those employees that is at least as effective as the protection provided to those employees by the Secretary's enforcement of this Act, the Secretary may publish a notice in the Federal Register setting forth that determination and the reasons for the determination and certifying that the Secretary has ceded jurisdiction to that Federal agency with respect to the specified standards or regulations affecting occupa-

tional safety and health. Such certification shall remain in effect unless and until rescinded by the Secretary.

"(2) The Secretary shall, by regulation, establish procedures by which any person may petition the Secretary to rescind a certification under paragraph (1). Upon receipt of such a petition, the Secretary shall investigate the matter and shall, within 90 days after receipt of the petition, publish a decision with respect to the petition in the Federal Register.

"(3) Any person who may be adversely affected by—

"(A) a decision of the Secretary certifying that the Secretary has ceded jurisdiction to another Federal agency pursuant to paragraph (1), or

"(B) a decision of the Secretary denying a petition to rescind such a certification,

may at any time prior to the sixtieth day after such decision is published in the Federal Register file a petition challenging such decision with the United States court of appeals for the circuit wherein such person resides or such person has a principal place of business for a judicial review of such decision. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary's decision shall be set aside if found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

"(4) Nothing in this Act shall apply to working conditions covered by the Federal Mine Safety and Health Act of 1977 (30 U.S.C. 801 et seq.).".

SEC. 303. APPLICATION OF OSHA TO DOE NUCLEAR FACILITIES.

Paragraph (6) of section 4(b) (29 U.S.C. 653(b)(6)) (as so redesignated) is amended to read as follows:

"(6) Notwithstanding paragraph (1) of this subsection, this Act shall apply with respect to employment performed in the Federal nuclear facilities under the control or jurisdiction of the Department of Energy.".

SEC. 304. EXTENSION OF EMPLOYER DUTIES TO ALL EMPLOYEES WORKING AT A PLACE OF EMPLOYMENT.

Section 5(a)(1) (29 U.S.C. 654(a)(1)) is amended by striking out "to each of his employees" and inserting at the end "or other employees at the place of employment".

TITLE IV—OCCUPATIONAL SAFETY AND HEALTH STANDARDS

SEC. 401. TIME FRAMES FOR SETTING STANDARDS.

(a) RECOMMENDATIONS AND PETITIONS FOR STANDARDS.—Paragraph (2) of section 6(b) (29 U.S.C. 655(b)(2)) is amended to read as follows:

"(2)(A) If the Secretary receives—

"(i) a recommendation of an advisory committee, the Secretary of Health and Human Services, or the Administrator of the Environmental Protection Agency, or

"(ii) a petition from an interested person which petition sets forth with reasonable particularity the facts which the person claims establish that an occupational safety or health standard should be promulgated, modified or revoked,

the Secretary shall, within 90 days after receipt of the recommendation or petition, publish in the Federal Register a response stating whether the Secretary intends to publish a proposed rule promulgating, modifying or revoking such standard.

"(B) If the Secretary's response states that the Secretary does not intend to publish a proposed rule, the Secretary shall set forth the reasons for that decision. In all other cases, the Secretary shall, within 12 months following the receipt of a recommendation or petition pursuant to subpararagraph (A), publish in the Federal Register a proposed rule promulgating, modifying, or revoking the standard cited in the petition or recommendation.".

(b) PROCEDURE FOR COMMENT AND HEARING.—Paragraph (3) of section 6(b) (29 U.S.C. 655(b)(3)) is amended—

(1) by designating the present language as subparagraph (B) and by striking out "under paragraph (2)"; and

(2) by inserting at the beginning the following:

"(3)(A) When information developed by the Secretary or submitted to the Secretary indicates that a rule should be proposed promulgating, modifying, or revoking an occupational safety or health standard, the Secretary shall publish such a proposed rule in the Federal Register and shall afford interested persons a period of at least 30 days after publication to submit written data or comments.".

(c) TIME FRAME FOR ISSUING RULES.—Section 6(b)(4) (29 U.S.C. 655(b)(4)) is amended—

(1) by striking out "sixty days" both places it appears and inserting in lieu thereof "180 days";

(2) by striking out "(2)" and inserting in lieu thereof "(3)(A)"; and

(3) by striking out "(3)" and inserting in lieu thereof "(3)(B).".

(d) REVIEW OF SECRETARY'S FAILURE OR REFUSAL TO ISSUE RULES.—Section 6 (29 U.S.C. 655) is amended by adding at the end the following:

"(h)(1) Any person who may be adversely affected by a determination by the Secretary under subsection (b)(2) not to propose a rule promulgating, modifying, or revoking a standard may at any time prior to the sixtieth day after such determination is published in the Federal Register file a petition seeking review of such determination with the United States court of appeals for the circuit wherein such person resides or such person has a principal place of business. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary's determination shall be set aside if found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

"(2) Any person who may be adversely affected by a failure of the Secretary to take any action required by subsection (b)(2)(B) within the time period prescribed therefor by such subsection may at any time after such period of time has elapsed file a petition for review stating that such action has been unlawfully withheld or unreasonably delayed. Such petition may be filed with the United States court of appeals for the circuit wherein such person resides or such person has a principal place of busi-

ness. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The reviewing court shall compel the Secretary to take any action that is found to have been unlawfully withheld or unreasonably delayed. The Secretary's desire to confer with, or to receive approval from any other Federal agency or Federal executive official, shall not justify the withholding or delaying of action by the Secretary, except where such consultation or solicitation of approval is required by applicable law and has been pursued in a timely fashion.".

(e) JUDICIAL REVIEW.—Section 6(f) (29 U.S.C. 655(f)) is amended by adding at the end the following: "Judicial review of a standard issued under this section may only be obtained by review under this subsection or subsection (h) and the validity of any such standard may not be raised in an enforcement action under section 11.".

SEC. 402. OCCUPATIONAL SAFETY AND HEALTH STANDARD.

Section 3(8) (29 U.S.C. 652(8)) is amended to read as follows:

"(8) The term 'occupational safety and health standard' means a standard which addresses a significant risk to the safety or health of employees by requiring conditions, or the adoption or use of one or more practices, means, methods, operations, or processes that most adequately assure, to the extent

feasible, safe and healthful employment and places of employment.".

SEC. 403. RECORDING OF WORK-RELATED ILLNESSES.

Section 6(b)(7) (29 U.S.C. 655(b)(7)) is amended by inserting after the third sentence the following: "The standard shall also prescribe requirements for recording or reporting a work-related illness determined as a result of a medical examination or test conducted under the standard.".

SEC. 404. PUBLIC DISCLOSURE OF ALL COMMUNICATIONS ON STANDARDS.

Section 6(b) (29 U.S.C. 655(b)) is amended by adding at the end the following:

"(9) The Secretary shall place all written comments and communications and a summary of all verbal communications with parties outside the Department of Labor (including communications with executive branch officials) regarding the promulgation, modification, or revocation of a standard under this section in the public record.".

SEC. 405. REVISION OF PERMISSIBLE EXPOSURE LIMITS.

Section 6 (29 U.S.C. 655) (as amended by section 401(d)) is amended by adding at the end the following:

"(i) In addition to other health and safety standards promulgated under subsection (b), the Secretary shall, in

cooperation with the Secretary of Health and Human Services, modify and establish exposure limits for toxic materials and harmful physical agents on a regular basis in the following manner and in accordance with the requirements of subsection (b)(5):

"(1) The Secretary of Health and Human Services, acting through the National Institute for Occupational Safety and Health, shall regularly evaluate available scientific evidence, data, and information to determine if exposure limits for toxic materials and harmful physical agents promulgated under subsections (a) and (b) should be modified or established to protect exposed employees from material impairment of health or functional capacity. Such evaluation shall include a review of the scientific literature, standards of private and professional organizations, national consensus standards, standards adopted by other countries, and recommendations of State and Federal agencies.

"(2) At least every 3 years the Secretary of Health and Human Services, acting through the National Institute for Occupational Safety and Health, shall, on the basis of the evaluation under paragraph (1), develop and shall transmit to the Secretary recommendations identifying toxic materials and harm-

ful physical agents, if any, for which exposure limits should be modified or established to protect employees from material impairment of health or functional capacity. For each such material or agent, the recommendation shall include a suggested permissible exposure limit, the basis for the suggested exposure limit, and, where available, information on feasible control measures.

"(3) Within 30 days of receipt of recommendations under paragraph (2), the Secretary shall publish the recommendations on exposure limits in the Federal Register and provide a period of 30 days for public comment. The Secretary shall evaluate the recommendations and public comments and, within 6 months of the receipt of the recommendations, the Secretary shall publish a proposed rule to modify, maintain, or establish exposure limits for each toxic material and harmful physical agent for which the Secretary of Health and Human Services has recommended that such limit should be modified or established. If a proposed exposure limit is not the same as the exposure limit recommended by the Secretary of Health and Human Services, the Secretary shall explain why the recommended limit is not being proposed.

"(4) Within one year of the publication of the proposed exposure limits under paragraph (3), the Secretary shall issue a final standard, which standard shall be subject to the requirements of subsection (b)(5). If a final exposure limit is not the same as the exposure limits recommended by the Secretary of Health and Human Services, the Secretary shall explain why the recommended exposure limit is not being adopted.

"(5) In addition to the periodic review of permissible exposure limits required by paragraph (1), the Secretary shall also establish or modify exposure limits for toxic materials and harmful physical agents whenever such action is warranted, pursuant to subsections (b)(5) and (g).".

SEC. 406. EXPOSURE MONITORING AND MEDICAL SURVEILLANCE.

Section 6 (29 U.S.C. 655) (as amended by section 405) is amended by adding at the end the following:

"(j) Within two years after the effective date of the Comprehensive Occupational Safety and Health Reform Act, the Secretary shall promulgate final standards on exposure monitoring and medical surveillance programs in the following manner and in accordance with subsection (b).

"(1) The standard on exposure monitoring shall include the following:

"(A) Requirements for a formal exposure assessment where workers may be exposed to toxic materials or harmful physical agents which are subject to standards issued under this section, including toxic materials or harmful physical agents covered by regulations published at 29 CFR 1910.1200.

"(B) Requirements for regular monitoring and measurement of toxic materials or harmful physical agents for which an exposure limit has been established by the Secretary or adopted by the employer if such monitoring and measurements will assist in protecting the health and safety of workers exposed to such toxic materials or harmful physical agents.

"(C) Requirements for a written compliance plan for reducing exposures where exposures are determined to exceed limits established by the Secretary or adopted by the employer.

"(D) Requirements for employees to be notified in writing of exposures to toxic materials or harmful physical agents above exposure lim-

its established by the Secretary or adopted by the employer and the steps the employer is taking to reduce such exposures.

"(E) Requirements for maintenance and access to records of exposure to toxic materials or harmful physical agents according to regulations published at 29 CFR 1910.20.

"(F) Requirements for any safety and health committee established under section 28 to review the exposure assessment and exposure monitoring program under subparagraphs (A) and (B), to observe exposure monitoring, to receive and have access to copies of assessment and monitoring results, to review written compliance plans, and to make recommendations with respect to such programs and plans.

"(2) The standard on medical surveillance programs shall include the following:

"(A) Requirements for an evaluation of employee exposure assessments and exposure monitoring to identify which employees may be at risk of material impairment of health or functional capacity due to exposure to toxic materials or harmful physical agents.

"(B) Requirements for periodic medical examinations for employees identified to be at risk of material impairment of health or functional capacity due to exposure to toxic materials or harmful physical agents where such examinations are appropriate to identify or to prevent material impairment to health or functional capacity.

"(C) Requirements for the evaluation of the results of medical examinations to determine if an employee or a group of employees are exhibiting indications of present or potential material impairment of health or functional capacity due to exposure to toxic substances or harmful physical agents.

"(D) Requirements for the notification of employees of the results of medical examinations in a manner that is understood by the employees.

"(E) Provisions setting forth the qualifications for health care providers who may conduct required medical examinations. Where feasible, the Secretary in cooperation with the Secretary of Health and Human Services shall establish criteria and procedures for the certification of

health care providers who conduct medical examinations.

"(F) Provisions to assure the confidentiality of personally identifiable medical information.

"(G) Provisions to prohibit discrimination against employees based on the results of medical examinations, and as appropriate provisions to provide protection of the wages, benefits, seniority and other relevant conditions of employment of employees who are transferred or removed from their jobs due to the result of medical examinations.

"(H) Records developed under this subsection shall be maintained and made available according to regulations published at 29 CFR 1910.20.

"(I) Requirements for the safety and health committee established under section 28 to review the employer's medical surveillance program and to make recommendations with respect thereto.".

SEC. 407. STANDARD ON ERGONOMIC HAZARDS.

Section 6 (29 U.S.C. 655) (as amended by section 406) is amended by adding at the end the following:

"(k) Within one year of the effective date of the Comprehensive Occupational Safety and Health Reform Act, the Secretary shall issue a final standard on ergonomic hazards to protect employees from work-related musculoskeletal disorders in accordance with subsection (b)(5). The standard shall include the following:

"(1) Requirement for an ergonomics program where employees are exposed to ergonomic hazards which requirements shall include provisions for hazard identification, control measures, medical management, training and education, and employee participation.

"(2) Requirements for an evaluation of job processes, work station design, rate of work, and work methods to identify ergonomic risk factors that cause or are likely to cause musculoskeletal disorders.

"(3) Requirements for control measures to reduce stressors and musculoskeletal disorders, including engineering controls, new equipment, or work organization controls.

"(4) Requirements for an effective medical management program for musculoskeletal disorders, including requirements for qualified health care pro-

viders, health surveillance, appropriate diagnosis, treatment, and follow up.

"(5) Requirements for recording musculoskeletal disorders as an illness and reporting such illnesses to the Secretary.

"(6) Requirements for training and education of employees exposed to ergonomic hazards on ergonomic risk factors, control measures, and the employer's medical management program.

"(7) Requirements for employee participation in the establishment and implementation of the employer's ergonomic program through any safety and health committee established under section 28.".

SEC. 408. TIMETABLE FOR SPECIFIC STANDARDS.

Section 6 (29 U.S.C. 655) (as amended by section 407) is amended by adding at the end the following:

"(l) The Secretary shall issue the following safety and health standards under subsection (b):

"(1) By November 1, 1991, the Secretary shall issue a final standard on blood borne pathogens.

"(2) By December 31, 1991, the Secretary shall issue final standards on—

"(A) permissible exposure limits for construction, maritime, and agriculture,

"(B) electric power generator, transmission, and distribution,

"(C) logging operations,

"(D) face, head, eye and foot protection

"(E) walking and working surfaces,

"(F) hazardous materials, and

"(G) motor vehicle inspection, maintenance, and safety.

"(3) By June 30, 1992, the Secretary shall issue final standards on—

"(A) cadmium,

"(B) confined space entry,

"(C) asbestos,

"(D) accreditation of training programs for hazardous waste operations, and

"(E) methylene chloride.

"(4) By December 31, 1992, the Secretary shall issue final standards on—

"(A) respiratory protection,

"(B) 1.3-butadiene,

"(C) scaffolds,

"(D) fall protection, and

"(E) glycol ethers.

"(5) By December 31, 1993, the Secretary shall issue final standards on—

"(A) indoor air quality, and

"(B) safety and health regulations for longshoring.".

TITLE V—ENFORCEMENT

SEC. 501. NO LOSS OF EMPLOYEE PAY FOR INSPECTIONS.

Section 8(e) (29 U.S.C. 657(e)) is amended by inserting after the first sentence the following: "Time spent by an employee on any such inspection shall be deemed to be hours worked and no employee shall suffer any loss of pay, benefits, or seniority for having participated in the inspection.".

SEC. 502. TIME FRAME FOR RESPONSE.

The last sentence of section 8(f)(1) (29 U.S.C. 657(f)(1)) is amended by inserting before the period the following: "within 30 days of receipt of the request for inspection".

SEC. 503. COMPLAINTS.

Section (8)(f)(1) (29 U.S.C. 657(f)(1)) is amended—

(1) by inserting "the Act or" after "a violation of"; and

(2) by adding at the end the following: "If the Secretary, upon notification from any other source, determines that there are reasonable grounds to believe that an imminent danger (as described in section 13(a)) or serious violation (as described in sec-

tion 17(k)) exists in a place of employment, the Secretary shall also make a special inspection in accordance with this section.".

SEC. 504. MANDATORY SPECIAL EMPHASIS.

Section 8 (29 U.S.C. 657) is amended by adding at the end the following:

"(h)(1) The Secretary shall establish and carry out a special emphasis inspection program for conducting inspections of industries or operations where—

"(A) existing hazards, or

"(B) newly recognized or new hazards introduced into worksites,

warrant more intensive than normal inspections, as determined by the Secretary.

"(2) The Secretary shall annually designate the industries and operations for the special emphasis inspection program and identify the number of special emphasis inspections that the Secretary plans to conduct in each designated industry and operation and the number of enforcement personnel required for such inspections.

"(3) Inspections conducted under paragraph (1) shall be in addition to other programmed and complaint inspections conducted under this Act before the effective date of the Comprehensive Occupational Safety and Health Reform Act.

"(4) The Secretary shall annually submit a report to the Congress on the special emphasis inspection program as part of the Secretary's annual report required under section 26 which includes information on inspections conducted pursuant to paragraph (2) which were carried out during the preceding year.".

SEC. 505. INVESTIGATIONS OF DEATHS AND SERIOUS INCIDENTS.

Section 8 (29 U.S.C. 657) (as amended by section 504) is amended by adding at the end the following:

"(i)(1) The Secretary shall investigate any work-related death or serious incident.

"(2) If a death or serious incident occurs in a place of employment covered by this Act, the employer shall notify the Secretary of the death or serious incident and shall take appropriate measures to prevent the destruction or alteration of any evidence that would assist in investigating the death or serious incident.

"(3) As used in this subsection, the term 'serious incident' means an incident that results in the hospitalization of 2 or more employees.".

SEC. 506. ABATEMENT OF SERIOUS HAZARDS DURING EMPLOYER CONTESTS.

(a) CITATIONS.—Section 9(a) (29 U.S.C. 658(a)) is amended by adding the following new sentence after the

third sentence thereof: "If the Secretary or an authorized representative of the Secretary believes that an alleged violation is serious and presents such a substantial risk to the safety or health of employees that the initiation of review proceedings should not suspend the running of the period for the correction of the violation, the citation shall so state.

(b) CITATIONS AND ENFORCEMENT.—Section 10 (29 U.S.C. 659) is amended as follows:

(1) in subsection (b), by striking out "(which period shall not begin to run until the entry of a final order by the Commission in the case of any review proceedings under this section initiated by the employer in good faith and not solely for delay or avoidance of penalties)";

(2) by adding at the end the following:

"(d)(1) The period permitted for correction of a violation shall begin to run from the date of receipt of the citation, except as provided in paragraphs (2) and (3).

"(2) If the employer initiates timely review proceedings under this section in which the employer contests matters other than the proposed assessment of penalty or characterization of the violation and the proceedings are initiated by the employer in good faith and not solely for delay, the period permitted for the correction of a violation

shall, except as provided in paragraph (3), not begin to run until the entry of a final order by the Commission.

"(3) If the citation states that the violation presents such a substantial risk to the safety and health of employees that the initiation of review proceedings shall not suspend the running of the period for correction of the violation and if, simultaneous with initiating timely review proceedings of that citation, the employer files a statement asserting that the period for correction of the violation should be suspended during the review proceedings, the Commission shall expedite the consideration and decision of the employer's review proceeding. In its decision resolving such proceeding, the Commission may modify the citation's provision that the period for correction of the violation shall run from the date of receipt of the citation, if the Commission determines, based on consideration of the nature of the violation, the nature and degree of risk posed to employees by the employer's refusal to undertake prompt correction of the violation, and the extent of any irreparable injury the employer would incur by undertaking correction of the violation during the pendency of review proceedings, that such provision is unreasonable in the circumstances.".

(c) PENALTIES.—Section 17(d) (29 U.S.C. 666(d)) is amended by striking out "(which period shall not begin

to run until the date of the final order of the Commission in the case of any review proceeding under section 10 initiated by the employer in good faith and not solely for delay or avoidance of penalties)".

(d) VERIFICATION OF ABATEMENT.—Section 10 (as amended by subsection (b)) is amended by adding at the end thereof the following:

"(e) Each employer to whom a citation for a serious, willful or repeated violation has been issued under section 9 shall verify the abatement of such violation in writing to the Secretary not later than 30 days after the period for correction of the violation has expired. In addition, each such employer shall prominently post, within 10 days after the verification of abatement, at or near each place a violation occurred a notice that the violation has been abated, and shall make available to employees and employee representatives for inspection a copy of the verification of abatement provided to the Secretary pursuant to this subsection. The Secretary shall issue regulations to implement this subsection within one year of the date of the enactment of the Comprehensive Occupational Safety and Health Reform Act.".

SEC. 507. RIGHT TO CONTEST CITATIONS AND PENALTIES.

The first sentence of section 10(c) (29 U.S.C. 659(c)) is amended by inserting after "files a notice with the Sec-

retary" the following: "alleging that the citation fails properly to designate the provisions of this Act, standard, rule, regulation, or order that have been violated or that the citation fails properly to designate the violation as serious, willful, or repeated, or that the proposed penalty is not adequate, or"

SEC. 508. RIGHT OF EMPLOYEE REPRESENTATIVES TO PARTICIPATE IN OTHER PROCEEDINGS.

The last sentence of section 10(c) (29 U.S.C. 659(c)) is amended by inserting after "participate as parties to hearings" the following: "or other proceedings conducted".

SEC. 509. OBJECTIONS TO MODIFICATION OF CITATIONS.

Section 10 (29 U.S.C. 659) (as amended by section 506(d)) is amended by adding at the end the following:

"(f)(1) If the Secretary intends to withdraw or to modify a citation as a result of any agreement with the cited employer, the rules of procedure prescribed by the Commission shall provide for prompt notice to affected employees or representatives of affected employees, which notice shall include the terms of the proposed agreement.

"(2) Within 15 working days of receipt of the notice provided in accordance with paragraph (1), any employee or representative of employees, regardless of whether such employee or representative has previously elected to participate in the proceedings, shall have the right to file a

notice with the Secretary alleging that the proposed agreement fails to effectuate the purposes of this Act and stating the respects in which it fails to do so.

"(3) Upon receipt of a notice filed under paragraph (2), the Secretary shall consider the matter, and if the Secretary determines to proceed with the proposed agreement, the Secretary shall respond with particularity to the statements presented in that notice.

"(4) Within 15 working days following the Secretary's response provided pursuant to paragraph (3), the employee or representative of employees shall, upon a request to the Commission, have the right to a hearing as to whether adoption of the proposed agreement would effectuate the purposes of this Act, including a determination as to whether the proposed agreement would adequately abate the alleged violations.

"(5) If the Commission determines that a proposed agreement fails to effectuate the purposes of this Act, the proposed agreement shall not be entered as an order of the Commission and the citation shall not be withdrawn or modified in accordance with the proposed agreement."

SEC. 510. IMMINENT DANGER INSPECTIONS.

(a) SPECIAL CONDITIONS AND PRACTICES.—Section 13 (29 U.S.C. 662) is amended—

(1) by striking out subsection (c), by redesignating subsections (a) and (b) as subsections (b) and (c), respectively, and by inserting before subsection (b) (as so redesignated) the following:

"(a)(1) If the Secretary determines, on the basis of an inspection or investigation under this section, that a condition or practice in a place of employment is such that an imminent danger to safety or health exists that could reasonably be expected to cause death or serious physical harm or permanent impairment of the health or functional capacity of employees if not corrected immediately, the Secretary shall so inform the employer and affected employees and shall request that the condition or practice be corrected immediately or that employees be immediately removed from exposure to such danger.

"(2) If the employer refuses to comply with the request under paragraph (1), the Secretary shall determine whether notice should be posted in the workplace pursuant to paragraph (3).

"(3) If the Secretary so authorizes, the Secretary shall immediately cause notice to be posted in the workplace identifying the equipment, process, or practice that is the source of the imminent danger. Such notice shall take the form of a tag or other device that will be seen by employees who might otherwise be exposed to the dan-

gerous equipment, process, or practice. The notice shall be removed only by the Secretary.

"(4) The fact that notice under paragraph (3) has been posted shall be noted in any citation issued pursuant to section 9 with respect to the hazard involved.

"(5) No person shall discharge or in any manner discriminate against any employee because such employee has refused to perform a duty that has been identified as the source of an imminent danger by a notice posted pursuant to paragraph (3). The right to refuse to perform such a duty shall be in addition to any other right to refuse to perform hazardous work that is afforded to employees by this Act, by standards or regulations issued pursuant to this Act, by contract, or by other applicable law."; and

(2) by amending the first sentence of subsection (b) (as so redesignated) to read as follows: "The United States district courts shall have jurisdiction, upon petition of the Secretary, to restrain any conditions or practices in any place of employment which pose an imminent danger as described in subsection (a).".

(b) PENALTIES.—Section 17 is amended by redesignating subsections (h) through (l) as subsections (i)

through (m), respectively, and by inserting after subsection (g) the following:

"(h) In the event that an employer does not immediately correct the hazard referenced in a notice posted under section 13(a)(3) or remove all employees from exposure thereto, the employer shall be assessed a civil penalty of not less than $10,000 and not more than $50,000 for each day during which an employee continues to be exposed to the hazard unless the Commission determines the condition or practice is not of such nature as to be covered by section 13(a).".

SEC. 511. CITATIONS AND PENALTIES FOR VIOLATIONS OF SECTION 27 AND SECTION 28.

(a) CITATIONS.—Section 9(a) is amended by inserting ", 27 or 28" after "section 5".

(b) PENALTIES.—Section 17 is amended—

(1) in subsection (a), by inserting ", 27 or 28" after "section 5",

(2) in subsection (b), by inserting ", 27 or 28" after "section 5", and

(3) in subsection (c), by inserting ", 27 or 28" after "section 5".

SEC. 512. OSHA CRIMINAL PENALTIES.

"(a) IN GENERAL.—Section 17 (29 U.S.C. 666) (as amended by section 510(b)) is amended—

(1) in subsection (e)—

"(A) by striking out 'fine of not more than $10,000' and inserting in lieu thereof 'fine in accordance with section 3571 of title 18, United States Code,';

"(B) by striking out 'six months' and inserting in lieu thereof '10 years';

"(C) by striking out 'fine of not more than $20,000' and inserting in lieu thereof 'fine in accordance with section 3571 of title 18, United States Code,'; and

"(D) by striking out 'one year' and inserting in lieu thereof '20 years';

(2) in subsection (f), by striking out "fine of not more than $1,000 or by imprisonment for not more than six months," and inserting in lieu thereof "fine in accordance with section 3571 of title 18, United States Code, or by imprisonment for not more than 2 years,";

(3) in subsection (g), by striking out "fine of not more than $10,000, or by imprisonment for not more than six months," and inserting in lieu thereof "fine in accordance with section 3571 of title 18, United States Code, or by imprisonment for not more than 1 year,";

(4) by redesignating subsections (i) through (m) as subsections (j) through (n), respectively;

(5) by inserting after subsection (h) the following:

"(i) Any employer who willfully violates any standard, rule, or order promulgated pursuant to section 6, or any regulation prescribed pursuant to this Act, and that violation causes serious bodily injury to any employee but does not cause death to any employee, shall, upon conviction, be punished by a fine in accordance with section 3571 of title 18, United States Code, or by imprisonment for not more than 5 years, or by both, except that if the conviction is for a violation committed after a first conviction of such person under this subsection, punishment shall be by a fine in accordance with section 3571 of title 18, United States Code, or by imprisonment for not more than 10 years, or by both,"; and

(6) by adding at the end the following:

"(o) If a penalty or fine is imposed on a director, officer, or agent of an employer under subsection (e), (f), (g), or (i), such penalty or fine shall not be paid out of the assets of the employer on behalf of that individual.".

(b) DEFINITION.—Section 3 (29 U.S.C. 652) is amended by adding at the end the following:

"(15) The term 'serious bodily injury' means bodily injury that involves—

"(A) a substantial risk of death;

"(B) protracted unconsciousness;

"(C) protracted and obvious physical disfigurement; or

"(D) protracted loss or impairment of the function of a bodily member, organ, or mental faculty.".

(c) JURISDICTION FOR PROSECUTION UNDER STATE AND LOCAL CRIMINAL LAWS.—Section 17 (29 U.S.C. 666) (as amended by subsection (a) of this section) is amended by adding at the end the following:

"(p) Nothing in this Act shall preclude State and local law enforcement agencies from conducting criminal prosecutions in accordance with the laws of such State or locality.".

TITLE VI—PROTECTION OF EMPLOYEES FROM DISCRIMINATION

SEC. 601. ANTIDISCRIMINATION PROVISIONS.

(a) EMPLOYEE ACTIONS.—Section 11(c)(1) (29 U.S.C. 660(c)(1)) is amended by adding at the end the following: "including reporting any injury, illness or unsafe condition to the employer, agent of the employer, the

safety and health committee, or employee safety and health representative."

(b) PROCEDURE.—Section 11(c) (29 U.S.C. 660(c) is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following:

"(2) No person shall discharge or in any manner discriminate against an employee for refusing to perform the employee's duties when the employee has a reasonable apprehension that performing such duties would result in serious injury to the employee or other employees. The circumstances causing the employee's apprehension of serious injury must be of such a nature that a reasonable person, under the circumstances then confronting the employee would conclude that there is a bona fide danger of an injury or serious impairment of health resulting from the circumstances. In order to qualify for protection, the employee must have sought from his employer, and have been unable to obtain, corrections of the circumstances causing the refusal to perform the employee's duties.

"(3) Any employee who believes that the employee has been discharged, disciplined, or otherwise discriminated against by any person in violation of paragraph (1) or (2) may, within 180 days after such alleged violation occurs, file (or have filed by any person on the employee's behalf) a complaint with the Secretary alleging such dis-

charge, discipline, or discrimination violates paragraph (1) or (2). Upon receipt of such a complaint, the Secretary shall notify the person named in the complaint of the filing of the complaint.

"(4)(A) Within 60 days of receipt of a complaint filed under paragraph (3), the Secretary shall conduct an investigation and determine whether there is reasonable cause to believe that the complaint has merit and notify the complainant and the person alleged to have committed a violation of paragraph (1) or (2) of the Secretary's findings. Where the Secretary has concluded that there is reasonable cause to believe that a violation has occurred, the Secretary's findings shall be accompanied by a preliminary order providing the relief prescribed by subparagraph (B). Thereafter, either the person alleged to have committed the violation or the complainant may, within 30 days, file objections to the findings or preliminary order, or both, and request a hearing on the record, except that the filing of such objections shall not operate to stay any reinstatement remedy contained in the preliminary order. Such hearings shall be expeditiously conducted. Where a hearing is not timely requested, the preliminary order shall be deemed a final order which is not subject to judicial review. Upon the conclusion of such hearing, the Secretary shall issue a final order within 120 days. In the interim,

such proceedings may be terminated at any time on the basis of a settlement agreement entered into by the Secretary, the complainant, and the person alleged to have committed the violation.

"(B) If, in response to a complaint filed under paragraph (3), the Secretary determines that a violation of paragraphs (1) or (2) has occurred, the Secretary shall order—

" (i) the person who committed such violation to correct the violation,

" (ii) such person to reinstate the complainant to the complainant's former position together with the compensation (including back pay), terms, conditions, and privileges of the complainant's employment, and

"(iii) compensatory damages.

If such an order is issued, the Secretary, at the request of the complainant, may assess against the person against whom the order is issued a sum equal to the aggregate amount of all costs and expenses (including attorney's fees) reasonably incurred, as determined by the Secretary, by the complainant for, or in connection with, the bringing of the complaint upon which the order was issued.

"(5)(A) Any person adversely affected or aggrieved by an order issued after a hearing under paragraph (4)(A)

may obtain review of the order in the United States Court of Appeals for the circuit in which the violation, with respect to which the order was issued, allegedly occurred, or the circuit in which such person resided on the date of such violation. The petition for review must be filed within 60 days from the issuance of the Secretary's order. Such review shall be in accordance with the provisions of chapter 7 of title 5, United States Code, and shall be heard and decided expeditiously.

"(B) Whenever a person has failed to comply with an order issued under paragraph (4)(A), the Secretary shall file a civil action in the United States district court for the district in which the violation was found to occur in order to enforce such order. In actions brought under this subparagraph, the district court shall have jurisdiction to grant all appropriate relief, including injunctive relief, reinstatement, and compensatory damages.

"(6) The legal burdens of proof that prevail under subchapter III of chapter 12 of title 5, United States Code, shall govern adjudication of protected activities under this subsection.".

TITLE VII—OSHA AND NIOSH TRAINING AND EDUCATION

SEC. 701. OSHA AND NIOSH TRAINING ACTIVITIES.

(a) EXPANSION.—Section 21 (29 U.S.C. 670) is amended—

(1) in subsection (a), by inserting after "educational programs to provide an adequate supply of qualified personnel to carry out the purpose of this Act," the following: ", including education programs for employees and members of safety and health committees, as appropriate.", and

(2) by adding at the end the following:

"(d) The Secretary shall develop, directly or by grants or contracts, training materials, model curricula, and programs to assist employers in providing the training and education required by section 27 and standards issued under section 6.".

TITLE VIII—RECORDKEEPING AND REPORTING

SEC. 801. DATA COLLECTED BY SECRETARY.

Section 24(a) (29 U.S.C. 673) is amended—

(1) by designating the first through third sentences as paragraphs (1) through (3), respectively; and

(2) by adding at the end the following:

"(4)(A) For the purpose of setting safety and health standards, targeting inspections to individual establishments, evaluating standard setting and enforcement programs, and for other purposes, the Secretary shall collect information and conduct analyses that identify—

"(i) industries, employers, processes, operations, and occupations that have a high rate of injury or illness;

"(ii) factors that cause or contribute to injuries and illnesses; and

"(iii) workers' compensation costs associated with the injuries and illnesses.

"(B) Data collected under subparagraph (A) shall be publicly available in a form suitable for further statistical analysis.

"(C) The Secretary shall issue regulations that require each employer covered by this Act to report to the Secretary each work-related death of an employee of the employer immediately upon knowledge of the employer and to report each serious incident that results in the hospitalization of 2 or more employees of the employer within 24 hours of the incident.".

SEC. 802. EMPLOYEE REPORTED ILLNESSES.

Section 8(c)(2) (29 U.S.C. 657(c)(2)) is amended—

"(1) by striking 'deaths, injuries and illnesses' and inserting 'deaths and injuries' and

"(2) by inserting before the period at the end the following: ', and work-related illnesses and suspected work-related illnesses (including a work-related illness reported by an employee or an employee's physician), unless the employer makes a reasonable determination that the illness is not work-related'.

SEC. 803. EMPLOYEE ACCESS.

Section 8(c)(2) (29 U.S.C. 657(c)(2)) is amended by adding at the end the following: "The records and reports required under this section shall be made available to the Secretary, to the Secretary of Health and Human Services, to employees, and to employee representatives.".

TITLE IX—NIOSH

SEC. 901. HAZARD EVALUATION REPORTS.

Section 20(a)(6) (29 U.S.C. 669(a)(6)) is amended—

(1) in the second sentence, by inserting ", whether any hazardous condition or harmful physical agent found in the place of employment poses a risk to exposed employees, after "as used or found"; and

(2) by inserting after the second sentence the following: "If a determination is not made within 6 months of the request, the Secretary shall provide the employer and employees with an interim report

on the known or suspected hazards, a recommendation for control, and an estimate of the time that a final determination will be made.".

SEC. 902. SAFETY RESEARCH.

Section 20(a) (29 U.S.C. 669(a)) is amended by adding at the end the following:

"(8) The Secretary of Health and Human Services shall identify major factors contributing to occupational injuries and deaths through accident investigations and epidemiological research.".

SEC. 903. INFORMATION AND EDUCATION ABOUT OCCUPATIONAL ILLNESSES.

Section 20(a) (29 U.S.C. 669(a)) (as amended by section 902) is amended by adding at the end the following:

"(9) The Secretary of Health and Human Services shall carry out a program to identify and notify employees at increased risk of occupational illnesses, injuries, and deaths, including public information and education programs for groups of workers at increased risk. In carrying out the program, the Secretary shall notify subjects of studies conducted or funded by the Secretary who are found to be at increased risk and shall make recommendations on appropriate medical surveillance for groups of employees at increased risk.".

SEC. 904. CONTRACTOR RIGHTS.

Section 20(b) (29 U.S.C. 669(b)) is amended in the first sentence by inserting after "Secretary of Health, Education and Welfare" the following: "or the Secretary's designees or contractors."

SEC. 905. NATIONAL SURVEILLANCE PROGRAM.

Section 20 (29 U.S.C. 669) is amended by adding at the end the following:

"(f)(1) The Secretary of Health and Human Services, acting through the National Institute for Occupational Safety and Health, shall (in cooperation with other agencies of the Department of Health and Human Services and the Secretary of Labor) establish a national surveillance program to identify cases of occupational illnesses, deaths, and serious injuries. In conducting the national surveillance program, the Secretary of Health and Human Services shall coordinate the activities of the Secretary with State health agencies and Federal and State workers' compensation agencies.

"(2)(A) The Secretary of Health and Human Services shall collect data each year on the number and characteristics of all occupational deaths, selected occupational illnesses, and selected occupational injuries.

"(B) In selecting occupational illnesses and injuries for the collection of data under subparagraph (A), the Secretary of Health and Human Services shall consider the

known frequency of the disorder, the severity of the disorder, and the size of the population at risk.

"(3) The Secretary of Health and Human Services shall prepare reports and analysis of deaths, occupational illnesses, and injuries collected under the national surveillance program and transmit the information to the Secretary of Labor, State health agencies, employers, employees, and other interested parties.

"(4) The Secretary of Health and Human Services may issue regulations to require an employer, through a physician or other health professional employed by or under contract to the employer, to report information on occupational deaths, illnesses and injuries in order to carry out the provisions of this subsection."

SEC. 906. ESTABLISHMENT OF NIOSH AS A SEPARATE AGENCY WITHIN PUBLIC HEALTH SERVICE.

The second sentence of section 22(b) (29 U.S.C. 671(b)) is amended by inserting after "The Institute shall be" the following: "established as a separate agency within the United States Public Health Service and be".

SEC. 907. CONFORMING AMENDMENTS CHANGING REFERENCES FROM HEW TO HHS.

The Occupational Safety and Health Act of 1970 is amended by striking out "Health, Education, and Welfare" each place it appears in sections 6 through 8 (29

U.S.C. 655 through 657) and sections 20 through 26 (29 U.S.C. 669 through 675) and inserting in lieu thereof "Health and Human Services".

TITLE X—STATE PLANS

SEC. 1001. STATE PLAN COMMITTEES AND PROGRAMS.

Section 18(c) (29 U.S.C. 667(c)) is amended—

(1) by striking "and" at the end of paragraph (7);

(2) by striking the period at the end of paragraph (8) and inserting a comma; and

(3) by adding at the end the following:

"(9) provides for the development of safety and health programs and safety and health committees and training programs that are at least as effective as those required under sections 27 and 28.".

SEC. 1002. ACCESS TO INFORMATION; EMPLOYEE RIGHTS.

Section 18(c) (29 U.S.C. 667(c)) (as amended by section 1001) is amended by adding at the end the following:

"(10) provides for reporting requirements, protection of employee rights, and access to information that are at least as effective as those required under this Act or other Federal laws which govern access to information related to this Act.".

SEC. 1003. APPLICATION OF FEDERAL STANDARDS.

Section 18 (29 U.S.C. 667) is amended by adding at the end the following:

"(i) In the event a State, within 6 months after the promulgation of a safety and health standard by the Secretary under section 6, fails to adopt or promulgate a standard which is at least as effective as the Secretary's standard, the State shall enforce the Secretary's standard until a State standard which is at least as effective as such standard is in effect.".

SEC. 1004. COMPLAINTS AGAINST A STATE PLAN.

Section 18 (29 U.S.C. 667) (as amended by section 1003) is amended—

(1) in the third sentence of subsection (e), by inserting after "preceding sentence" the following: "except as provided in subsections (f) and (j)"; and

(2) by adding at the end the following:

"(j)(1) If the Secretary receives a written complaint from an employer, employee, or employee representative that a State is deficient in it compliance with a provision of its State plan and the Secretary determines that there are reasonable grounds to believe that such deficiency exists, the Secretary shall promptly investigate any such complaint, except that complaints which allege a deficiency in an enforcement action by a State shall be investigated within 30 days of the receipt of the complaint.

"(2) The Secretary shall, within 30 days of completion of any investigation, transmit the findings in writing to the State and to the complainant, which findings include recommendations to correct any deficiency which is identified. If the Secretary determines there are no reasonable grounds to believe that a deficiency exists, the Secretary shall notify the complainant in writing of such determination.

"(3) Within 30 days of the receipt of a finding issued under paragraph (2), the State shall respond to the Secretary in writing as to what action the State has taken in response to the Secretary's findings and recommendations.

"(4) If after receipt of the response of the State the Secretary believes a serious violation of this Act exists for which the State has failed to issue a citation, the Secretary with reasonable promptness shall issue a citation.".

SEC. 1005. ACTION AGAINST STATE PLAN.

Section 18(f) (29 U.S.C 667(f)) is amended—

(1) by designating the first sentence as paragraph (1);

(2) by redesignating the second sentence as paragraph (3); and

(3) by inserting after paragraph (1) (as so designated) the following new paragraph:

"(2)(A) If the Secretary determines at any time that there are reasonable grounds for concluding there is a failure to comply substantially with any provision of the State plan (or any assurance contained therein), the Secretary shall give notice to the State of the deficiencies which, in the Secretary's view, warrant such withdrawal of approval, and shall allow 6 months for the correction of the deficiencies.

"(B) If after 6 months the Secretary determines that the State has not corrected the deficiencies and that grounds for withdrawing approval of the State plan still exist, the Secretary shall institute proceedings pursuant to paragraph (3) for the withdrawal of approval of the plan, unless the Secretary determines in writing that exceptional circumstances exist that justify a decision not to institute such proceedings.

"(C) During the pendency of proceedings pursuant to paragraph (3), the Secretary shall exercise jurisdiction, concurrent with the State, over the safety and health issues that are subject to the State plan.".

SEC. 1006. STATE PLAN CONFORMING AMENDMENTS.

Section 18 (29 U.S.C. 667) (as amended by section 1003) is amended by adding at the end the following:

"(k) Each State which is exercising authority to operate a State safety and health plan under this section shall

within one year of the effective date of the Comprehensive Occupational Safety and Health Reform Act modify the plan to conform with the requirements of this Act.".

TITLE XI—VICTIM'S RIGHTS

SEC. 1101. VICTIM'S RIGHTS.

Section 29 is amended to read as follows:

"SEC. 29. VICTIM'S RIGHTS.

"(a) DEFINITION.—For purposes of this section, the term 'victim' means—

"(1) an employee who has sustained a work-related injury or illness which is the subject of an inspection or investigation conducted under section 8, or

"(2) a family member of an employee if the employee is killed as a result of a work-related injury or illness which is the subject of an inspection or investigation of a death or serious incident conducted under section 8 and the employee cannot reasonably exercise the rights of an employee under this section.

"(b) RIGHTS.—On request, a victim shall be afforded the right, with respect to a work-related injury, illness, or death involving the victim, to—

"(1) meet with the Secretary or an authorized representative of the Secretary respecting the inspection or investigation conducted under section 8 con-

cerning the victim's injury, illness, or death before the Secretary's decision to issue a citation or to take no action, and

"(2) receive, at no cost, a copy of any citation or report issued as a result of such inspection or investigation on the date the citation or report is issued, be informed of any notice of contest filed under section 10, and be provided an explanation of the rights of employees and employee representatives to participate in proceedings conducted under section 10.

For purposes of section 10, a victim shall have the same rights as an employee.

"(c) MODIFICATION OF CITATION.—Before entering into an agreement to withdraw or modify a citation issued as a result of an inspection or investigation of a death or serious incident under section 8, the Secretary, on request, shall provide an opportunity to the victim involved to appear and make a statement before the parties conducting any settlement negotiations.

"(d) REMEDIES.—If this section is violated, a victim shall be entitled to—

"(1) declaratory relief,

"(2) injunctive relief,

"(3) recovery of any costs incurred in securing the documents referred to in subsections (b)(2) and (c), and

"(4) reasonable attorney's fees and costs.

"(e) NOTIFICATION.—The Secretary shall take reasonable actions to inform victims of their rights under this section.".

TITLE XII—WORKER'S COMPENSATION STUDY

SEC. 1201. COMMISSION.

(a) ESTABLISHMENT.—There is established the Federal Worker's Compensation Commission (hereinafter in this title referred to as the "Commission").

(b) MEMBERSHIP.—The Commission shall be composed of 15 members appointed as follows:

(1) 7 members shall be appointed by the President. One of such members shall be the Chairman.

(2) 4 members shall be appointed by the Speaker of the House of Representatives. The Speaker may appoint a Member of Congress to serve on the Commission.

(3) 4 members shall be appointed by the Majority Leader of the Senate. The Majority Leader may appoint a Member of the Senate to serve on the Commission.

8 members of the Commission shall constitute a quorum for the purpose of doing business.

(c) DUTIES.—The duties of the Commission are as follows:

(1) The Commission shall review the recommendations of the National Commission on State Workmen's Compensation Laws to determine the extent such recommendations were implemented, to identify barriers to such implementation which existed or still exist, and to determine if the recommendations which were not implemented are still appropriate.

(2) The Commission shall study the feasibility of utilizing worker's compensation data to target loss prevention activities on high risk occupations.

(3) The Commission shall examine worker's compensation laws to determine—

(A) the effectiveness of the laws in meeting financial and medical needs of injured workers,

(B) the adequacy of the administrative system under such laws and the appropriateness of such laws being the exclusive remedy for injuries and deaths in light of disputes, litigation, and delays in resolving cases brought under such laws,

(C) whether such laws provide adequately for occupational illnesses and diseases and provide for quality control and medical and rehabilitation costs with cost control.

(D) whether such laws provide sufficient time for recuperation and counseling before an injured or ill worker returns to full duty,

(E) the relationship between worker's compensation, safety and health programs, and insurance rates and services,

(F) the feasibility and appropriateness of transferring the branch of the Department of Labor involved in worker's compensation studies from the Employment Standards Administration to the Occupational Safety and Health Administration, and

(G) the feasibility of preempting State worker's compensation laws with a national program.

(4) The Commission shall transmit to the President and the Congress not later than two years after the effective date of this Act a final report containing a detailed statement of its findings, conclusions, and recommendations.

(d) AUTHORITY.—

(1) The Commission or, on the authorization of the Commission, any subcommittee or members thereof, may, for the purpose of carrying out subsection (c), hold such hearings, take such testimony, and sit and act at such times and places as the Commission deems advisable. Any member authorized by the Commission may administer oaths or affirmations to witnesses appearing before the Commission or any subcommittee or members thereof.

(2) Each department, agency, and instrumentality of the executive branch of the Government, including independent agencies, shall furnish to the Commission, upon request made by the Chairman, such information as the Commission deems necessary to carry out its functions under subsection (c).

(3) Subject to such regulations as may be adopted by the Commission, the Chairman shall have the power to—

(A) appoint and fix the compensation of an executive director, and such additional staff personnel as the Chairman deems necessary, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of

chapter 53 of such title relating to classification and General Schedule pay rates, but at rates not in excess of the maximum rate for GS–18 of the General Schedule under section 5332 of such title, and

(B) procure temporary and intermittent services to the same extent as is authorized by section 3109 of title 5, United States Code.

(4) The Commission may enter into contracts with Federal or State agencies, private firms, institutions, and individuals for the conduct of research or surveys, the preparation of reports, and other activities necessary to the discharge of its duties.

(5) Members of the Commission who are not Members of Congress shall receive compensation for each day they are engaged in the performance of their duties as members of the Commission at the daily rate prescribed for GS–18 under section 5332 of title 5, United States Code, and shall be entitled to reimbursement for travel, subsistance, and other necessary expenses.

TITLE XIII—EFFECTIVE DATE

SEC. 1301. EFFECTIVE DATE.

This Act and the amendments made by this Act shall become effective on the date that is 90 days after the date of the enactment of this Act.

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APPENDIX J

APPENDIX J

SUMMARY OF THE COMPREHENSIVE OCCUPATIONAL SAFETY AND HEALTH REFORM ACT

A. EMPLOYER AND EMPLOYEE PARTICIPATION

1. Safety and Health Programs

The bill requires employers to establish and maintain safety and health programs to reduce or eliminate hazards and to prevent injuries and illnesses to employees. Such programs must provide for, among other things, employee training and education. OSHA is authorized to modify the application of these requirements to classes of employers provided that protection of employees is not diminished.

The requirement for health and safety programs will force employers to participate more actively in preventing illnesses and injuries. Too often, employers limit their health and safety activities to compliance with specific OSHA standards when a systematic approach could identify and correct hazards before accidents and illnesses occur.

Already, employers in California and Washington must develop written health and safety programs. OSHA encourages employers to develop written programs and the General Accounting Office (GAO) recommends that Congress consider making such programs mandatory.

2. Joint Safety and Health Committees

The bill requires employers of 11 or more employees to establish safety and health committees made up of an equal number of employee and employer representatives. In unionized settings, employee representatives are to be designated by the employees' bargaining representative; otherwise they are to be elected directly by the affected employees. The joint committees are authorized to review the employer's safety and health program, conduct inspections, and make advisory recommendations to the employer.

The John Gray Institute recently concluded that joint health and safety committees have a positive effect on workplace safety. In plants with joint committees, employees are more likely to report hazards, alerting management to problems before accidents occur; have less fear of reprisal; and are more likely to participate in health and safety activities, believing management is receptive to their suggestions. Health and safety concerns can be addressed by the Committee, thereby reducing reliance on OSHA's inspectors to abate worksite hazards. And cooperation between employers and employees on safety issues limits the adversarial relationship between OSHA and employers.

Joint health and safety committees are not a new idea: the United Auto Workers and Chrysler established the first joint health and safety committee in the auto industry; all three U.S. automakers have had joint health and safety committees since 1973. Just this week, in a report about the petro-chemical industry, the John Gray Institute found that 85 percent of plants in the industry have joint health and safety committees. GAO has found almost half of all collective bargaining agreements require joint health and safety committees and many nonunion employers have established such committees. Washington State requires joint health and safety committees for employers with 11 or more workers, and GAO recommends that OSHA consider mandating health and safety committees as well.

3. Employee Participation in Enforcement Proceedings

The bill mandates OSHA investigation of fatalities and serious incidents and increases employee participation during inspections. The bill also allows affected employees to more actively participate in Commission proceedings by authorizing employee challenges and Commission review of citations, penalties, and settlement agreements between employers and OSHA and by expanding employee participation in the enforcement process in other respects.

The bill would expand employee rights to participate in Review Commission proceedings. Current law limits employee participation, allowing workers only to initiate challenges to the abatement period. By increasing employee participation in settlements--unions have long protested their exclusion from settlement discussions--OSHA would obtain a more balanced view of plant health and safety.

4. Antidiscrimination Protections

The bill incorporates expanded antidiscrimination protections modeled on the Surface Transportation Act. These provisions prohibit employers from discharging or otherwise retaliating against an employee because the employee has reported an unsafe condition or because the employee has refused to perform hazardous work that would expose the employee to a bona fide danger of injury or serious impairment of health.

The bill also revises existing procedures for the handling of discrimination complaints, and authorizes the Secretary of Labor to order reinstatement and assess back pay, compensatory damages and attorneys' fees if the Secretary finds that an employee has been discharged or discriminated against in violation of the Act.

Although OSHA now includes a provision protecting employees from discrimination, according to GAO, OSHA inspectors believe workers will be subject to retaliation if they freely participate in health and safety activities. No wonder workers are reluctant, particularly in nonunion settings, to participate in health and safety activities. Strengthening OSHA's antidiscrimination provisions is intended to change that perception.

OSHA's retaliation ban has been ineffective, in part, because only the Secretary can enforce the provision in District Court and the Secretary pursues few cases. The bill borrows the retaliation enforcement procedures of the Surface Transportation Act, which the Department of Labor (DOL) already administers, so employees have a more effective remedy against illegal retaliation and can pursue that remedy in an administrative proceeding.

'HE STANDARD SETTING PROCESS

'he process by which OSHA adopts health and safety standards ›een criticized by virtually every participant. OSHA relies ıformal rule-making to set standards, but the process ·theless polarizes labor and management so the proceedings adversarial. Controversy over standards has resulted in ;sive delays. A handful of standards--lead, ›ut/tagout--have taken OSHA more than a decade to complete ımplement; it is now common for standards to take more than years from OSHA's announced intent to regulate to final . Since OSHA was passed in 1970, the agency has adopted : than 30 comprehensive health standards, and most safety ıards have not been revised since the 1960's.

›elays have grown much worse since 1981. Administration ;ials now see their job as protecting business from ıation rather than protecting workers from occupational ·ds. Further, the Office of Management and Budget (OMB) now ›-manages all aspects of OSHA standard setting--from OSHA's ıation of technical scientific data to cost nates--further dragging out an already time-consuming ess.

1. Prompt Response To New Information

The bill requires OSHA to respond to petitions for health and safety standards within 90 days of receipt, and if the agency finds that a standard is warranted, to issue a proposed rule within 12 months of the petition and a final rule within six months after the comment period or hearing. Judicial review is available to challenge OSHA's failure to regulate or to adhere to the mandatory time frames.

The bill requires an OSHA response to requests that agency adopt a new standard promptly and further ires, when a standard is warranted, that OSHA issue expeditiously. While current law imposes deadlines SHA standard-setting, the courts have ruled those lines are advisory. The bill aims to impose latory, but realisti:, time limits on standards vity.

The provisions authorizing judicial review when OSHA s to regulate are a codification of existing tice, except that OSHA's desire to consult with other cies, such as OMB, about a standard is not a valid on for delay.

ting Exposure Limits

While 2,000-3,000 new chemicals are developed each , OSHA regulates workplace exposure to only toxins. Under the bill, OSHA must revise and update e exposure limits every three years. The bill ires the National Institute of Occupational Safety Health (NIOSH) to submit recommendations for isions of permissible exposure limits for toxic stances every three years, and requires OSHA to pond to NIOSH recommendations by issuing a proposed e within six months and a final rule 12 months later.

OSHA often permits higher exposures than consensus ups recommend because the process of modifying health ndards is so slow. The bill provides a streamlined cedure for updating permissible exposure limits which not be controversial; OSHA retains its existing hority to issue comprehensive health standards, where ropriate.

iance on Feasibility Analysis

The bill amends the definition of an occupational ety and health standard and requires that all ndards address a "significant risk" to workplace lth or safety and reduce that "significant risk" to extent feasible.

The Supreme Court has ruled that OSHA may regulate y "significant risks" to worker health. The bill ifies the Supreme Court's decision. It is worth ing, however, that OSHA's "significant risk" t--OSHA regulates risks greater than one in 00--permits 1,000x greater risk to workers than gress permitted under the Clean Air Act for exposures air toxics.

The Supreme Court has ruled, that when OSHA regulates health hazards, it must set the standard that best protects worker health and that industry is capable of achieving. In contrast, when regulating safety hazards, OSHA balances worker safety against compliance costs, sacrificing worker health where OSHA concludes safety precautions are too expensive The bill would require that safety standards, like OSHA health standards, must fully protect workers, eliminating the artificial distinction between these two types of standards.

4. Specific Standards

The bill requires OSHA to issue standards on a number of specific health and safety issues, including exposure monitoring , medical surveillance, and ergonomic hazards, within specific time frames.

OSHA promised in 1989 to issue standards that generally require employers to monitor employee exposure to toxins and to provide medical surveillance to exposed workers. OSHA regulates the exposure levels for 600 chemicals, but for all but 30 chemicals, employers have no ancillary duty to measure employee exposures and to monitor employee health. The bill would close this gap.

The bill also requires OSHA to publish an ergonomics standard within two years. Between 1981 and 1989 reported cases of cumulative trauma disorders have increased fivefold; about one in 500 American workers now suffer from this disorder, which is often irreversible.

The bill also imposes mandatory deadlines for OSHA to issue specific standards. OSHA has committed itself to developing each standard named in the bill and, in all but a few instances, the deadline imposed by the bill is the time OSHA's regulatory agenda projects the standard will be completed.

C. ENFORCEMENT

1. Targeted Inspection Program

The bill requires OSHA to establish a special emphasis inspection program to target high-risk industries and operations.

2. Reports and Investigations

The bill requires employers to report within 24 hours, and requires OSHA to investigate, all work-related fatalities and serious incidents resulting in the hospitalization of two or more employees.

The [illegible]ne bill makes two changes to existing law. First, it lowers [illegible]rs the reporting threshold. Now employers must notify OS[illegible]OSHA of a death or an incident where five employees [illegible]es are hospitalized; under the bill, OSHA must be notified [illegible]d of a death or incident involving two hospitali[illegible]lizations. Second, notice must be provided within 24 hours[illegible]s, and not the 48 hours permitted under current law, so w[illegible]o when OSHA arrives, it can investigate what happened[illegible]d.

Imminent [illegible]nt Danger

Whe[illegible]nere OSHA determines that a condition or practice poses an [illegible]n imminent danger of death or serious harm to employees [illegible]es unless immediately corrected, the bill authorize[illegible]zes OSHA to tag the hazard and to require the employer [illegible]r to take immediate corrective action. Employees who refus[illegible]ruse to work on dangerous equipment would be protecte[illegible]ted against discrimination, and OSHA is authorized to fine [illegible]e an employer who fails to take corrective action up to $5[illegible]$50,000 per day.

Now[illegible]ow, when OSHA identifies an imminent danger, it must see[illegible]eek a temporary restraining order from Federal District [illegible]t Court before it can require that the danger be correcte[illegible]ted or employees removed from the hazard. Employee[illegible]es remain exposed to the danger while judicial proceedi[illegible]ings go forward. The bill would provide an alternat[illegible]ative procedure. When OSHA tags an imminent danger, [illegible]. an employer who fails to correct the danger will face su[illegible]ubstantial penalties if OSHA's action is upheld. OSHA ret[illegible]etains its present authority to proceed in the courts.

The [illegible]ne Mine Safety and Health Administration has the authorit[illegible]ity to shut down dangerous operations, and this authorit[illegible]ity has been used sparingly--in fewer than 1 percen[illegible]ent of inspections. Inspectors in California also have shu[illegible]hut-down authority and, according to GAO, use it in about or[illegible]one percent of inspections.

Abatemen[illegible]ment

Un[illegible]nder the bill, OSHA may require that the period for abating [illegible]g substantial health and safety hazards begins to run whe[illegible]en the employer receives a citation. In this limited [illegible]d circumstance, the decision to contest an OSHA violati[illegible]ion does not suspend the running of the abatement period. [illegible]. The bill also requires the employer to verify that th[illegible]he hazard is abated.

The law now provides that employers are not required to abate violations while they are contesting an OSHA citation. This provision may permit employers to defer abatement of serious hazards for several years or more. If a hazard exists, employee exposure is needlessly prolonged.

The bill would leave this general rule unchanged, except in cases posing a substantial risk, where OSHA may decide abatement should begin immediately. In such cases, employers may obtain expedited review before the Commission. GAO has recommended that Congress consider protecting workers while a citation is being contested.

5. Criminal Penalties

The bill increases to ten years in prison the maximum criminal penalty available under the Act for knowing, willful violations that cause death, and authorizes criminal penalties for knowing, willful violations that cause serious bodily injury, with a maximum prison sentence of five years.

GAO has noted the potential benefits of expanded reliance on criminal sanctions to deter willful violations of OSHA. The law now has limited criminal sanctions that are rarely used--only one employer has been sent to jail since 1970. Federal OSHA criminal penalties are substantially less stringent than criminal penalties under environmental law or state criminal law.

D. EXPANSION OF COVERAGE

1. Government Employees

The bill extends the coverage of the Act to federal, state and local government employees, and to employees working in federal nuclear facilities under the jurisdiction of the Department of Energy.

Hundreds of thousands of government employees have no protection from on-the-job health and safety hazards. The bill would extend coverage to these employees.

2. Overlapping Federal Jurisdiction

When two federal agencies regulate employee working conditions, the bill permits OSHA to cede jurisdiction over regulation of particular safety and health hazards to the other agency only if OSHA certifies that agency has and is enforcing a standard at least as effective as the applicable OSHA standard. OSHA may not exercise jurisdiction over mining.

Currently, OSHA cannot regulate any working condition which may be regulated by another federal agency. Thus, when the Federal Aviation Administration (FAA) specifies maintenance procedures mechanics must follow to ensure airline safety, the FAA rules preempt OSHA regulation of on-the-job hazards. Mechanics facing job hazards have no protection.

3. General Duty Clause

The general duty clause is also modified to clarify its application at multiemployer worksites, where hazardous conditions or practices may affect not only the employer's own employees, but also other employees working at the site.

The provision implements a recent recommendation of the John Gray Institute that OSHA require plant management to assume responsibility for all workers on site. Thus, a refinery owner would become responsible for the safety of all workers at the site--even temporary contract workers. Likewise, a general contractor at a construction site would be ultimately responsible for the safety of employees working for a subcontractor.

E. STATE PLANS

The bill requires state plans to include provisions regarding employer safety and health programs, joint safety and health committees, reporting, nondiscrimination and access to information which are at least as effective as those provided by federal law. In addition, the bill requires OSHA to investigate complaints against State plans and modifies the procedures for withdrawal of approval of a State plan.

The Act now requires OSHA to withdraw approval of State plans which fail effectively to protect against job hazards. Although some States protect workers very well, others do not. OSHA's only leverage over errant State plans is to withdraw approval and assume the full cost of protecting employees in that State. Not surprisingly, OSHA has never withdrawn approval for a State plan.

The bill would provide an intermediate step which would allow OSHA to notify a State of deficiencies in its plan and provide the State with an opportunity to correct those deficiencies before OSHA considers withdrawal of the State plan.

F. RESEARCH, TRAINING AND RECORDKEEPING

1. Training and Data Collection

The bill requires OSHA to develop model training curricula on programs for dissemination to employers, and improves the collection of employer data regarding work-related deaths, injuries and illnesses.

2. National Institute of Occupational Safety and Health (NIOSH)

The bill requires NIOSH to establish a program to identify and notify employees who are at increased risk of suffering work-related injuries or illnesses, and a national surveillance program to identify and collect data on work-related injuries and illnesses.

G. VICTIMS RIGHTS

The bill guarantees the victims of workplace accidents or illness, or their families, access to information on OSHA's investigation and citations, if any, about their accident. The bill also requires OSHA to meet with victims or their families before setting a citation involving their accident.

H. WORKER'S COMPENSATION

The bill establishes a Federal Worker's Compensation Commission with 15 appointed members. The Commission is charged, among other things, with examining compensation laws to evaluate their effectiveness and determining whether they adequately compensate workers who have suffered work-related injuries or illnesses.

APPENDIX K

FIGURE
Assessment Guide for Occupational Health Nursing Practice

Standard	Criteria	Level of Practice: All of the Time	Most of the Time	Some of the Time	Not at All	N.A	Comments, Recommendations
I. FUNCTION The OHN collaborates with management in developing objectives for the employee health service compatible with the company's corporate goals and objectives.	Structure 1. Functions: a) as manager for the health program and policy maker; b) under the supervision of a qualified occupational health nurse; c) as part of overall management in the development of policies for the health unit.						
	Process 1. Develops philosophy and written goals and objectives for the occupational health program. 2. Conducts periodic reviews of Occupational Health Services to assure goals and objectives are being met. 3. Keeps informed of legal requirements of occupational health programs and assures compliance with same, i.e., medical surveillance, recordkeeping, etc. 4. Communicates findings to other members of management team and makes recommendations for programs and intervention strategies. 5. Conveys costs and benefits of occupational health programs in the workplace to management by: a) analysis of data; b) literature documentation.						
	Outcome 1. Occupational health programs are developed and implemented to: a) meet health needs of individual employees; b) assure optimal health and safety of all employees. 2. Occupational health programs are in compliance with federal and state laws. 3. The OHN is a member of the interdisciplinary team responsible for occupational health and safety.						
II. FUNCTION/ STANDARD The OHN administers the employee health service.	Structure 1. The health service is managed by a qualified registered occupational health nurse. 2. The occupational health unit is of adequate size and quality and is suitably located to perform the nursing functions of the occupational health program. 3. The OHN is familiar with the products and processes of the company which affect health.						
	Process 1. Develops and coordinates written policies and procedures with other members of the health team and management. 2. Determines the number and qualifications of nursing and paraprofessional staff that are required for a comprehensive on-site occupational health program. 3. Identifies and supervises the nursing care which can safely be performed by allied health workers. 4. Develops and monitors operating budget.						

Figure: Assessment guide for occupational health nursing practice.

FIGURE (continued)
Assessment Guide for Occupational Health Nursing Practice

Standard	Criteria	Level of Practice: All of the Time	Most of the Time	Some of the Time	Not at All	N/A	Comments/ Recommendations
	5. Collects data and prepares reports on the health status of the worker and the existing or potential health hazards in the work environment. 6. Provides management with data on trends in health-related statistics to inform them of the impact of occupational health program planning and implementation.						
	Outcome 1. The occupational health program is comprehensive and an integral part of the workplace. 2. The OHN is responsible for managing the occupational health department.						
III. FUNCTION/ STANDARD The OHN defines nursing authority and responsibility based on standards of service and practice established by the nursing profession and collaborates with management in determining the nurses' position in the organization structure	Structure 1. A written organizational chart is established for the health unit. 2. Written job descriptions are developed and available for all levels of nursing and allied staff. 3. Orientation programs and continuing educational plans are established for all nursing and allied personnel.						
	Process 1. Functions within his/her level of preparation and experience in accordance with state and federal regulations for practice. 2. Attends educational and professional programs and meetings on a regular periodic basis to practice and promote state-of-the-art occupational health nursing.						
	Outcome 1. Evaluations to measure performance based on completion of activities defined in their job descriptions are conducted on an annual basis by the OHN manager.						
IV. FUNCTION The OHN administers nursing care. Develops nursing care procedures and protocols with specific goals and interventions outlining occupational health nursing actions unique to employee needs.	Structure 1. a. There is a written policy and procedure manual for nursing activities. b. A method exists for nursing care procedures and protocols to be communicated to appropriate personnel and health care providers. 2. Recordkeeping and reporting systems are in place which meet legal requirements, ensure continuity of care and confidentiality, and are coordinated with the company's systems. 3. Written, signed and dated medical directives or protocols are provided and updated at least annually.						
	Process 1. Identifies employee health needs and collaborates with health care providers in establishing nursing care procedures and protocols. 2. Actively participates in: a. Preplacement assessments, periodic and special health assessments; and b. Determines health risk factors, employee and company needs in relation to job placement.						

FIGURE (continued)
Assessment Guide for Occupational Health Nursing Practice

Standard	Criteria	Level of Practice: All of the Time	Most of the Time	Some of the Time	Not at All	N/A	Comments Recommendations
	3. Nursing care: a. is individualized to meet the physical, emotional, social, and cultural needs of employees b. ensures optimal opportunities for employees with special needs. c. is based on measures of prevention and health promotion. 4. Demonstrates professional judgment and skill in patient assessment, nursing care, counseling, and evaluation techniques. 5. Renders professional nursing care and follow up of occupational and non-occupational illness and injuries within the scope of the company's medical directives and the nurse practice act.						
	Outcome 1. Nursing care policies and procedures are recorded and available for review. 2. Nursing care policies and procedures are revised and periodically updated as goals are achieved or changed. 3. Accurate, complete and concise records of nursing activities are maintained. 4. Records are audited for appropriate treatment and/or referral.						
V. FUNCTION The OHN coordinates responsibilities in the health assessment program and promotes health maintenance and prevention of illness and injury.	Structure 1. The preventive approach to health care, which includes early detection, medical monitoring, health teaching and counseling with appropriate referral is a primary concern of the occupational health program. 2. Company sponsored health and wellness programs have been established by the OHN to assist employees in improving and maintaining their health. 3. A mechanism exists for the OHN to periodically reevaluate employee health and safety needs.						
	Process 1. Plans, coordinates, implements, and evaluates on-site health education programs, including teaching on-site health education programs. 2. Intervenes appropriately on behalf of individuals and populations at risk of preventable, potential health problems. 3. Intervenes for an employee who evidences an acute illness, injury or temporary disabling condition. 4. Ensures that the employee is informed about his/her current health status. 5. Conducts or collaborates with other team members regular plant walk throughs and health tours to assess potential or existing environmental, health and safety hazards. 6. Informs corporate personnel, when appropriate, about adaptations or interventions, of the work environment required to meet individual employee health needs. 7. Provides education, support and motivation in areas of health and safety.						
	Outcome 1. Health problems of employees are identified at an early stage. 2. Employees utilize information provided in making decisions and choices about promoting, maintaining, and restoring health, and seeking and utilizing appropriate health care personnel and health care resources.						

FIGURE (continued)
Assessment Guide for Occupational Health Nursing Practice

Standard	Criteria	Level of Practice: All of the Time	Most of the Time	Some of the Time	Not at All	N.A	Comments/ Recommendations
	3. Employees demonstrate healthy lifestyle choices and an understanding of disease and accident prevention. 4. Employees, including handicapped, chronically and terminally ill, show evidence of participation in the work force activities to the fullest extent possible in relation to each individual's health status.						
VI. FUNCTION The OHN collaborates with other on-site members of the occupational health team to evaluate the work environment and utilizes outside resources when services are not available within company.	Structure 1. Functions as a member of the interdisciplinary health and safety team and as a resource person to other team members to establish parameters of service. 2. Coordinates the health care of the employees. 3. Is consulted, when appropriate, in selection of personal protection wear. 4. Coordinates and/or assists in development of safety education program, policies and procedures.						
	Process 1. Utilizes state, federal and private agencies and resources for assistance as needed. 2. Provides information to management to assist company in adhering to OSHA regulations, fire codes, SARA and Hazard Communication, recognizing safety as a priority.						
	Outcome 1. The OHN is part of a professional team, the goals of which are to provide a healthy and safe work environment for all employees. 2. The OHN defines his/her role and responsibility in contributing to the provision of a safe and healthy work environment.						
VII. FUNCTION The OHN establishes and promotes working relationships with appropriate community agencies.	Structure 1. Acts as a member of management team and as a liaison to the community.						
	Process 1. Establishes contact with agencies and services of the community that might be a reciprocal basis for a "good neighbor" policy (i.e., American Red Cross for Blood Drives, CPR, First Aid, Catastrophic Assistance etc.; American Cancer Society, Police with substance abuse assistance; Fire Department with Right to Know data, etc.). 2. Coordinates employee education programs with appropriate community agencies.						
	Outcome 1. The OHN is an integral part of management team by solidifying good public relations within the community. 2. Community health resources available for support are utilized in accomplishing health service goals and objectives.						

* If not applicable, N/A, please explain, i.e., This is not a responsibility of the OHN, this is a responsibility of the supervising nurse, corporate offices, physicians, personnel, safety, etc.

APPENDIX L

APPENDIX L

BROWN'S (1981) NINE FUNCTIONS OF THE OHN

1. Participate in the formulation of the occupational health unit protocols.
   - Review the policies and procedures of the occupational health service.
   - Review the job descriptions of the members of the occupational health service.
   - Review with the occupational health nurse the method for developing protocols and policies for the occupational health nursing service.

2. Provide primary care for injured or ill workers.
   - Deliver nursing care to employees with work related injury or illness.
   - Delivery nursing care to employees with non-work related injury or illness.
   - Review the forms required to document injuries and illnesses eg, OSHA log, Worker's Compensation forms.
   - Assess the worker's need for follow-up or referral and make recommendations.
   - Review methods of coding illnesses and injuries using the International Classification of Diseases literature.
   - Use approved nursing diagnoses when documenting a worker's illness or injury
   - Keep accurate, confidential health records.

3. Counsel and/or provide crisis intervention for workers and interpersonal, family and/or work related problems.
   - Review the Employee Assistance Program at the worksite.
   - Identify the nurse's role and the occupational health service role in Employee Assistance Programs and counseling.
   - Speak with an Employee Assistance Program counselor.
   - Discuss with a supervisor how the Employee Assistance Program is used for their employees.
   - Identify resources in the community that might be used when providing crisis intervention.

4. Consult on health and safety matters that affect the worker.
   - Attend a meeting of the health and safety committee.
   - Identify volunteer or community organizations that may be used for consultation on health and safety concerns.
   - Keep workers and managers apprised of new developments in health and safety by newsletters, memos, etc.

5. Participate in preplacement and periodic health assessments of workers.
   - Participate in preplacement and periodic health assessment.
   - Review system of notification for periodic health assessments, eg, "tickler files."
   - Participate in a screening program.

6. Participate in programs that aim to identify, eliminate, and/or control health and safety hazards.
   - Meet with a representative of the Industrial Hygiene Department and discuss the role of the department in environmental control programs.
   - Meet with a representative of the Safety Department and discuss the role of the department in the environmental control program.
   - Identify any follow-up as a result of an injury due to a safety hazard.

7. Educate workers on illness prevention, health promotion, and use of the health care system.
   - Plan a group health education program.
   - Provide health education as needed during an individual consultation with an employee.
   - Provide information on available health resources in the community.

8. Participate in planning, conducting, and evaluating the many activities that maintain the health of the worker.

   - Identify cost-containment measures that might be implemented at the worksite.
   - Speak with a representative of Labor Relations to understand their effect on the well-being of the worker.
   - Perform a worksite assessment to describe the employee population and identify which health activities would be appropriate for that group.
   - Become familiar with the disability program and the record keeping system used at the worksite.
   - Identify quality assurance measures for occupational health nursing.

9. Fulfill an ombudsman's role for those workers who require help in understanding their rights and assist workers to enter and utilize the health care system.
   - Make referrals as needed.
   - Teach a class on consumerism and how it relates to the health care system today.
   - Plan a visit with the benefits department

APPENDIX M

APPENDIX M

STAGES OF THE PRECEPTING PROCESS

Planning ---------->	Precepting -------->	Evaluating
♦ Making the Commitment	♦ Role Modeling	♦ Student: Reviewing Objectives Analyzing New Skills
♦ Setting Objectives	♦ Facilitating: Experiences Interfaces Networking Professionalism Independence	♦ Preceptor Identifying Benefits to Worksite Analyzing Impact on Worksite Perpetuating Excellence in Occupational Health
♦ Contracting		
♦ Developing Activity List		
♦ Gaining Approvals		

Feedback to Planning Phase
Adaptation and/or Modification

APPENDIX N

APPENDIX N

EXPECTED OUTCOMES OF A PRECEPTORSHIP

STUDENT
- Improved occupational health nursing skills
- Network established within the profession
- Clarified career goals
- Increased self confidence
- Improved skills in conducting research
- Eased transition from academic to work world
- Increased marketability of graduate occupational health nurse
- Eased transition from academic to work world
- Potential employment opportunities

WORKSITE
- Increased staff motivation
- Improved access to consultation and resources of the university
- Answered research questions
- Potential recruitment of occupational health nursing graduate as new staff member
- Written evaluation of the student's clinical experience
- Increased visibility for company and company occupational health nursing program

UNIVERSITY
- Increased availability of possible research sites
- Increased variety and number of clinical facilities available to future students
- Network established with occupational health community
- New ideas for future clinical experiences
- Practical application of innovations in occupational health
- Potential employment placement of participating student
- Heightened awareness of occupational health nurse program